MEDICARE: A PROFILE

February 1995

PREFACE

Medicare is the world's largest health insurance program, and by many measures one of the most successful. It provides access to high quality health services for more than 37 million of this nation's frailest and most disabled citizens, with an administrative cost of only 2 percent. It has pioneered in new methods of provider payment, new technologies of quality assurance, and electronic data transmission. And it has played the central role in the development of new models of health care delivery while helping to strengthen and preserve essential institutions in thousands of communities throughout the country.

For a program so large and so successful, however, Medicare is often not very well understood. Much of the public discussion of Medicare appears to be based on simple misunderstandings or misperceptions. We hope that the assembly and presentation of a few essential facts about the program and its beneficiaries will contribute to better understanding of Medicare by policymakers, analysts, and the general public.

As Medicare approaches its 30th anniversary in the midst of a rapidly changing health care system and a complex socioeconomic environment, we hope that a clearer understanding of the basic facts about Medicare will strengthen the process of adapting the program to meet the challenges of the future as successfully as it has met those of the past.

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February, 1995

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EXECUTIVE SUMMARY

Profile of the Medicare Population

- Medicare is a nationwide health insurance program for the elderly and for persons under 65 who are receiving Social Security benefits on the basis of disability or who are suffering from "end stage renal disease".

- Reflecting the overall aging of the population, the Medicare population is growing faster than the general population. The two groups of beneficiaries with the most extensive health care needs, the aged over 85 and those with end-stage renal disease, are the two fastest growing parts of the Medicare population.

Program Spending

- Cost containment in the Medicare program is working: Medicare spending is growing more slowly (7.7% annually over the 1984-1993 period) than that of private insurers (9.8% annually over the same period).

- Medicare's administrative costs are much lower than those of private insurers: 2% of Medicare spending goes to administrative expenses compared to about 25% in the small group market and about 5% in the large group market.

- The majority of Medicare expenditures are made on behalf of beneficiaries with modest incomes: in 1992, 60% of program spending was incurred on behalf of those with incomes less than $15,000; 80% of program spending was on behalf of those with incomes of less than $25,000.

Health Spending for the Elderly

- The elderly account for a disproportionate share of national spending on medical care: at 12% of the population they absorb 36% of health care expenditures, or four times as much as the under 65 population.

Access to Care

- Physician visits increased since the physician fee schedule was introduced in 1992.

- Although Medicare does not generally cover preventive services, those that are covered, such as screening mammography, have not been fully utilized: over a two year period, only 37% of female Medicare beneficiaries are receiving mammography screening exams and only 28% of African-American women.

Managed Care

- Enrollment of Medicare beneficiaries in managed care is growing rapidly; 1994 saw a 25% increase from the previous year. To date, 3.1 million beneficiaries, 9% of the program population are enrolled in managed care plans. The proportion of managed care organizations offering a plan to Medicare beneficiaries has also grown to 70% of all HMOs.

GLOSSARY

AAPCC	Adjusted Average Per Capita Cost. The basis of payment for Medicare risk HMOs, the AAPCC is a yearly projection of program expenditures in fee-for-service Medicare (i.e. beneficiaries not enrolled in HMOs). Medicare pays risk HMOs 95% of the AAPCC for each enrolled Medicare beneficiary, based on the beneficiary's county of residence.
Administrative costs	Includes costs for marketing, enrollment, customer services, claims processing, and profits.
Aged	As used here, those 65 years of age and over.
Ambulatory care sensitive condition	Condition that should not require hospitalization with appropriate ambulatory treatment.
Ambulatory surgical center	A facility that provides surgical services that do not require a hospital stay. Medicare pays for use of an ambulatory surgical center for certain approved surgical procedures. Medicare will also pay for physician and anesthesia services that are provided for the procedure.
Assigned claim	A claim for which the physician or supplier agrees to accept the amount approved by Medicare as the total payment. Medicare pays the physician or supplier 80% of the Medicare approved amount. The doctor or supplier can charge the beneficiary only for the coinsurance, which is the remaining 20% of the approved amount. A *participating* physician or supplier agrees to accept assignment on all claims.
BDMS	Bureau of Data Management and Strategy. This HCFA component maintains data on beneficiary eligibility, and the utilization and cost of program benefits.

BPO	Bureau of Program Operations. This HCFA component is responsible for Medicare claims processing operations and related functions. Private insurance companies under contract to HCFA known as carriers and intermediaries, process Medicare claims.
CMP	A managed care organization that is not a federally-qualified HMO but which meets Medicare statutory requirements for entering into a Medicare risk contract.
Cost-based HMO	An HMO which is paid by Medicare for the actual cost of providing care to Medicare enrollees. The term includes cost HMOs, cost CMPs and HCPPSs.
CRS	Congressional Research Service of the Library of Congress. Data on administrative costs of private health insurers is from "Costs and Effects of Extending Health Insurance Coverage", prepared in 1988.
DHHS	Department of Health and Human Services.
End-stage renal disease (ESRD)	Irreversible kidney failure. To survive, the patient must either receive a kidney transplant or undergo periodic kidney dialysis.
ESRD facility	A facility that provides renal dialysis services.
Federally-qualified HMOs	An HMO which meets Federal requirements for certification as a prepaid health plan that is able to offer a comprehensive range of services through a specified network of providers.
HCFA	The Health Care Financing Administration, a part of the Department of Health and Human Services, administers the Medicare and Medicaid programs.
HCPP	Health care prepayment plan. A managed care organization that contracts with HCFA to enroll Medicare beneficiaries for coverage of some or all Medicare-covered physician and supplier services. HCPPs are always paid on a reasonable cost basis.
Health Care Financing Review	A quarterly journal published by HCFA's Office of Research and Demonstrations (ORD).

Health professional shortage area	A geographic area determined by the U.S. Public Health Service to have a shortage of physicians and other health professionals.
HMO	Health Maintenance Organization. HMOs provide or arrange for a comprehensive package of health care services for a fixed monthly premium with nominal copayments permitted.
HMO penetration	The percentage of insured lives in a market area enrolled in HMOs.
Home health agency	A public or private agency that specializes in giving skilled nursing services and other therapeutic services, such as physical therapy, in patients' homes.
Home health benefit	The portion of the Medicare program that pays for care to homebound beneficiaries. Care must be provided by a home health agency which participates in the Medicare program. Covered services include part-time or intermittent skilled nursing care, physical and speech therapy, occupational therapy and part-time or intermittent services of a home health aide.
Hospice	A public agency or private organization that is primarily engaged in providing pain relief, symptom management, and supportive services to terminally ill people. Medicare beneficiaries may elect to receive hospice care instead of standard Medicare benefits for terminal illnesses.
Managed care plan	A general term applied to a wide range of insurance plans, including HMOs, where choice of providers is limited and administrative measures control utilization of services. The types of Medicare managed care plans include health maintenance organizations (HMOs), competitive medical plans (CMPs), and health care prepayment plans (HCPPs).
MCBS	Medicare Current Beneficiary Survey. A sample of Medicare beneficiaries are interviewed to collect information on demographic characteristics, health status and functioning, insurance coverage, financial resources and family supports. The beneficiaries are re-interviewed periodically to form a continuous profile of their health care experience.
Medicaid	A joint Federal-state program that provides medical assistance for those with low incomes. Medicaid is administered by the States and jointly funded by the States and the Federal government. It was

	authorized in 1965 by Title XIX of the Social Security Act.
Medicare Select	A HCFA demonstration project authorized in 15 states. Medicare Select are Medigap plans that limit coverage to services delivered through a specified network of providers. If a beneficiary uses a non-network provider other than for emergency services, the Medicare Select plan is not obligated to reimburse the beneficiary's incurred deductible or copayment. Medicare program payments are nevertheless made for both network and non-network services.
Medicare supplemental insurance	Private insurance which supplements Medicare by paying Medicare deductibles and coinsurance. There are ten nationally standardized policies (plans A to J). Some policies offer coverage not provided by Medicare, such as coverage for outpatient prescription drugs and care outside the U.S. Also called Medigap Insurance.
Medigap insurance	See Medicare supplemental insurance.
NCHS	National Center for Health Statistics. The component of the U.S. Public Health Service which collects and maintains statistics on various aspects of public health.
Non-institutionalized	Individuals not living in facilities such as nursing homes.
Nursing home	A general term applied to skilled nursing facilities, and facilities providing custodial care.
OACT	Office of the Actuary. This HCFA component provides estimates of expenditures for the Medicare and Medicaid programs and of health expenditures in the U.S.
OBRA	Omnibus Budget and Reconciliation Act of a given year.
OLIGA	Office of Legislative and Inter-Governmental Affairs. This HCFA component coordinates Medicare and Medicaid legislative strategies and congressional hearings, and facilitates relationships with Congress and the States.

OIG	Office of the Inspector General. This component of the Department of Health and Human Services conducts evaluations to promote program effectiveness and investigations to detect fraud and abuse.
OMC	Office of Managed Care. This HCFA component administers the Medicare and Medicaid managed care programs.
ORD	Office of Research and Demonstrations. This is the HCFA component which conducts or sponsors research in health policy issues and conducts demonstrations of new health care delivery and payment mechanisms.
Participating physician/supplier	A physician or supplier who has agreed to accept assignment on all Medicare claims (see assignment).
Risk HMO	An HMO that is paid a pre-determined per-member payment from Medicare to provide all necessary covered services to its Medicare enrollees.
Skilled care	Skilled nursing care or skilled rehabilitation services, such as physical therapy. Medicare pays for nursing home stays requiring daily skilled care for a condition related to a prior hospitalization. Medicare also pays for part-time or intermittent skilled care provided by a home health agency to those who are homebound.
SNF	Skilled Nursing Facility. A facility which is certified by Medicare to provide skilled nursing or rehabilitation services.
Supplier	A firm which provides durable medical equipment (such as wheelchairs and oxygen equipment), prosthetic and orthotic devices (artificial limbs and braces), or medical supplies (such as surgical dressings).
USPCC	United States per capita cost. The national average expenditure per person incurred by the Medicare program.
Zero Premium HMOs	HMOs which offer Medicare beneficiaries services not covered by Medicare at no additional premium and no copayments or deductibles.

PROFILE OF MEDICARE BENEFICIARIES

HIGHLIGHTS

- The population of Medicare beneficiaries is growing older and more disabled. People over age 85 and those with end-stage renal disease have been the fastest growing categories of beneficiaries.

- Approximately 30% of, or 11 million, Medicare beneficiaries rated their health status as fair or poor, compared to only about 10% of the general U.S. population.

- Nearly twice as many beneficiaries over age 85 are women. More than half of female beneficiaries over age 85 have difficulties with three or more activities of daily living, such as eating, bathing, or toileting.

- More than one-quarter of all beneficiaries live alone. Of those, nearly 10%, or one million, are functionally impaired, having three or more activity limitations. These people are the group most at risk for entering a nursing home. Female beneficiaries are more than twice as likely to live alone as male beneficiaries.

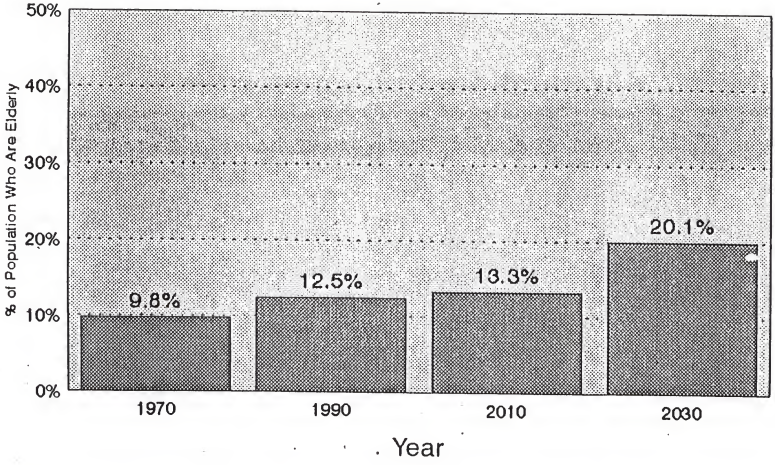
- The large majority of beneficiaries are white, with nine percent African-American, five percent Hispanic and two percent of other races/ethnicities. The racial composition of beneficiaries in urban and rural areas is roughly equivalent.Profile of Medicare Beneficiaries

The Medicare population is growing older and more disabled.

- The U.S. population is aging rapidly, creating significant growth in the numbers of individuals eligible for Medicare. In 1970, people age 65 years or older were only about 10% of the total U.S. population; by 1990 that number had risen to 12%; and by 2030 those 65 years or older are projected to constitute 20% of the U.S. population (Chart P-1). The impact of an aging Medicare population on expenditures is significant, since, on average, the aged tend to be sicker and consume four times as much health care per capita as the under 65 population.

The Aging of the U.S. Population

Percent of Total Population Who Are Elderly



Source: U.S. Bureau of the Census, Current Population Reports
Figures for the years 2010 and 2030 are projections.

Chart P-1

Changing Composition of the Medicare Population.

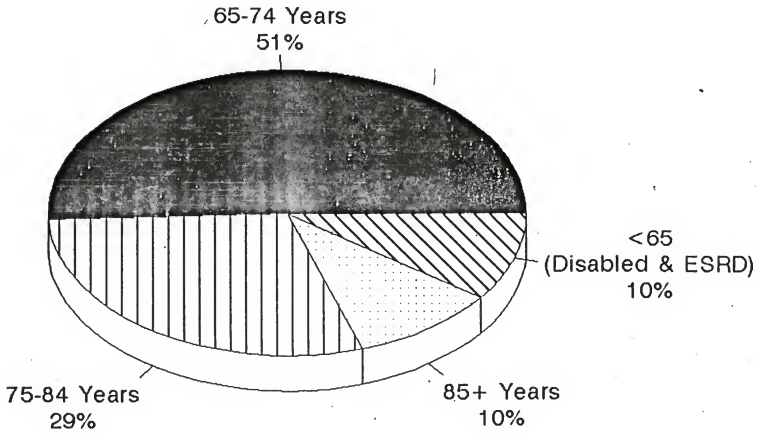
- In 1992, the aged (those 65 years and older) made up 90% of the Medicare population, and the disabled and those with end-stage renal disease (ESRD) made up the remaining 10% (Chart P-2).

- People over the age of 85, the disabled, and those with end-stage renal disease (ESRD) have been the fastest growing groups of Medicare beneficiaries over the last decade (respectively, between 1982-1992, average annual rate of growth of 3%, 4%, and 10%). This growth trend is expected to continue. By the year 2010, those over the age of 85 will make up 11% of the Medicare population (Chart P-3). The number of ESRD enrollees is expected to more than double between 1990 and 2010, rising from 65,000 to 132,000 in 2010.

- The disabled, particularly the younger disabled, are becoming a greater proportion of the Medicare population. The disabled now make up approximately 10% of the Medicare population, and projections indicate that number will increase to 17% by the year 2010 (Chart P-3).

The Composition of the Medicare Population, 1992

Elderly, Disabled & ESRD



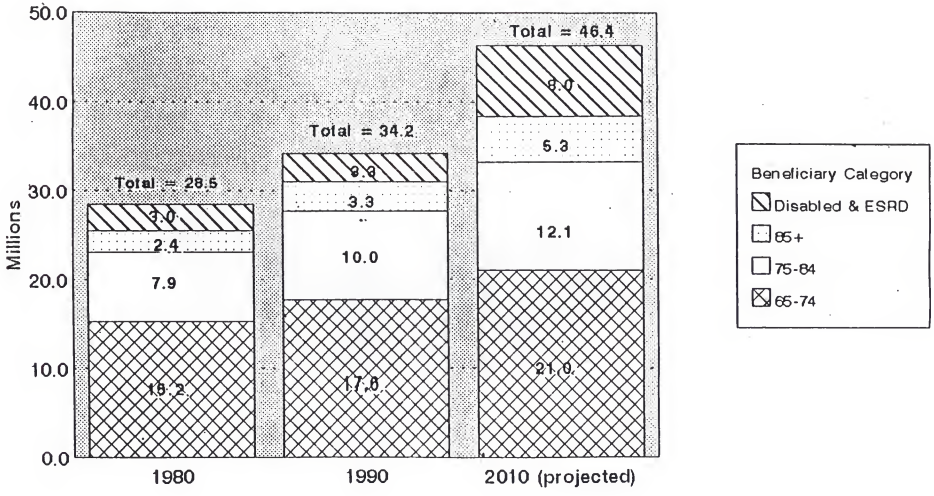
Total Beneficiaries = 35.6 Million

Source: HCFA/BDMS

Chart P-2

Growth of the Medicare Population

Elderly, Disabled & ESRD



Source: HCFA/BDMS/OACT

Chart P-3

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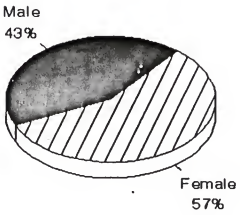
Gender, Race, and Residence of Medicare Beneficiaries.

- Significantly more females than males are enrolled in the Medicare program, primarily because of the slightly longer life expectancy of females (Chart P-4). The proportion of female beneficiaries over the age of 85 is nearly double that of male beneficiaries (13% vs 7%).

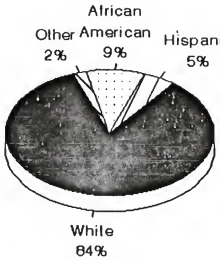
- The large majority of the Medicare population is white (84%). African-Americans make up 9% of enrollees, Hispanics 5%, and all other races/ethnicities are 2% of enrollees (Chart P-4).

- Three-quarters of Medicare beneficiaries live in urban areas. The racial composition of beneficiaries in urban and rural areas is approximately the same: white beneficiaries comprise 87% of the total in rural areas and 84% in urban areas, African-Americans make up 7% in rural areas and 9% in urban areas, and other races or unknown make up 6% of the rural and 7% of urban enrollees (Chart P-4).

Distribution of Medicare Population
By Gender, Race, and Residence, 1992



Gender



Race

Residence

Source: HCFA/BDMS/OACT: Medicare Current Beneficiary Survey, 1992

Chart P-4

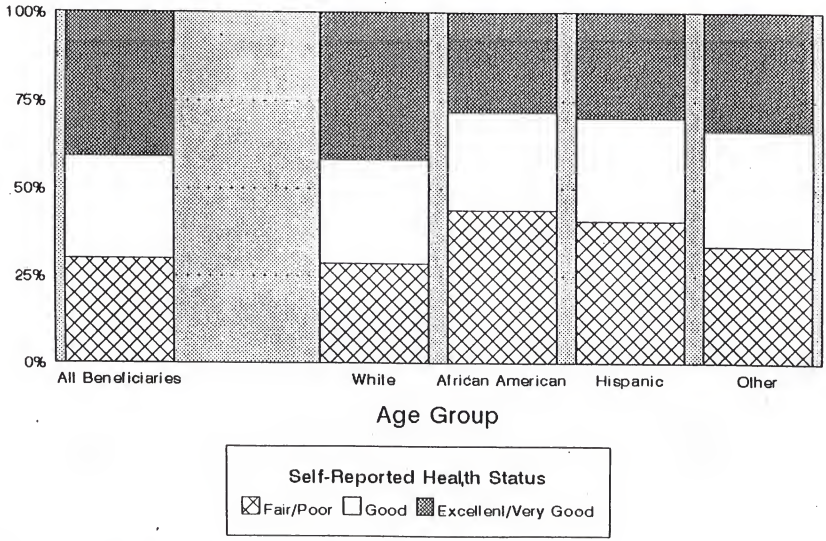
In a recent survey, almost 11 million Medicare beneficiaries rated their health status as fair or poor. A larger proportion of African-Americans and Hispanics rated their health as fair or poor compared to whites.

- Approximately 30%, or 11 million, of Medicare beneficiaries rated their health as fair or poor. Only about 10% of the total U.S. population (civilian, non-institutionalized) reported fair or poor health*.

- Self-reported health status varies by race and age. Forty-four percent of African-Americans and 41% of Hispanics reported fair or poor health, compared to 28% of whites (Chart P-5). Thirty-six percent of the elderly over 85 years reported their health to be fair or poor (Chart P-6)

* Source: NCHS/National Health Interview Survey, 1992

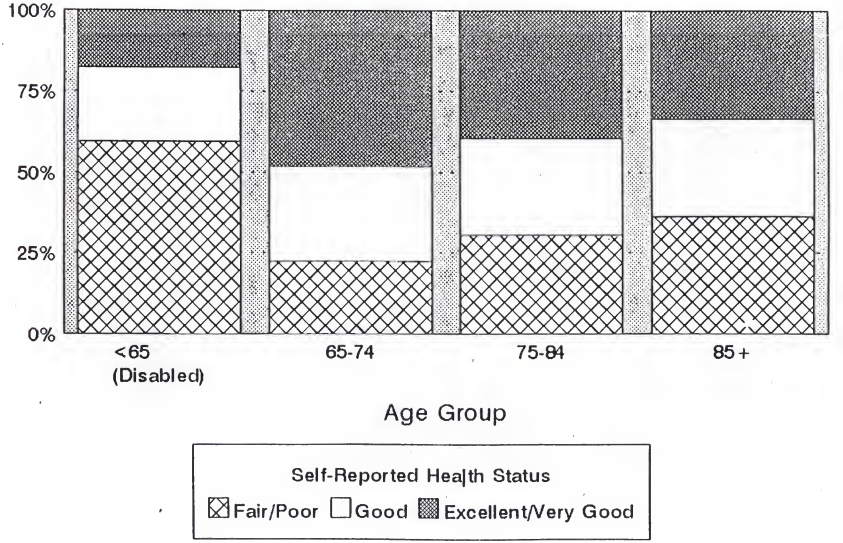
Self-Reported Health Status of Medicare Beneficiaries by Race, 1992



Source: HCFA/OACT: Medicare Current Beneficiary Survey, 1992

Chart P-5

Self-Reported Health Status of Medicare Beneficiaries by Age, 1992



Source: HCFA/OACT: Medicare Current Beneficiary Survey, 1992

Chart P-6

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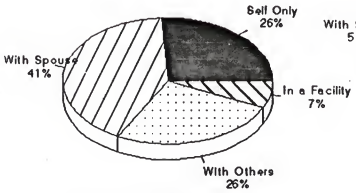
Medicare beneficiaries who live alone and are functionally impaired or in poor health are most at risk for entering a nursing home. Women make up a disproportionate share of those who live alone.

- More than one quarter (nearly 10 million) of Medicare beneficiaries live alone (Chart P-7). Many of those who live alone are in poor health: more than one-quarter of beneficiaries who live alone rate their health as fair or poor and 9% are significantly functionally impaired, having three or more activity limitations+(Chart P-8). These people are most at risk for entering a nursing home.

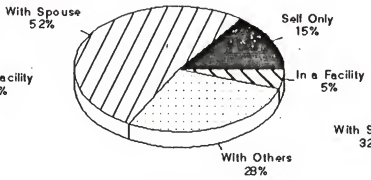
- Medicare beneficiaries who live alone are disproportionately female and poor. More than one-third (34%) of female beneficiaries live alone, compared to only 15% of male beneficiaries (Chart P-6). More than half of all beneficiaries who live alone have incomes less than $10,000 -- nearly 80% of whom are women (Chart P-8).

+ Note: Activities of daily living (ADLs) include eating, bathing, dressing, toileting, getting in and out of bed, and moving about their living area. Instrumental activities of daily living (IADLs) are generally defined as activities that are necessary to remain independent, such as housework, laundry, grocery shopping, taking medication, and transportation.

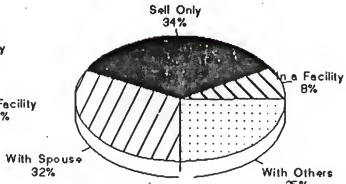
Living Arrangements of Medicare Beneficiaries, 1992



All Beneficiaries



Males

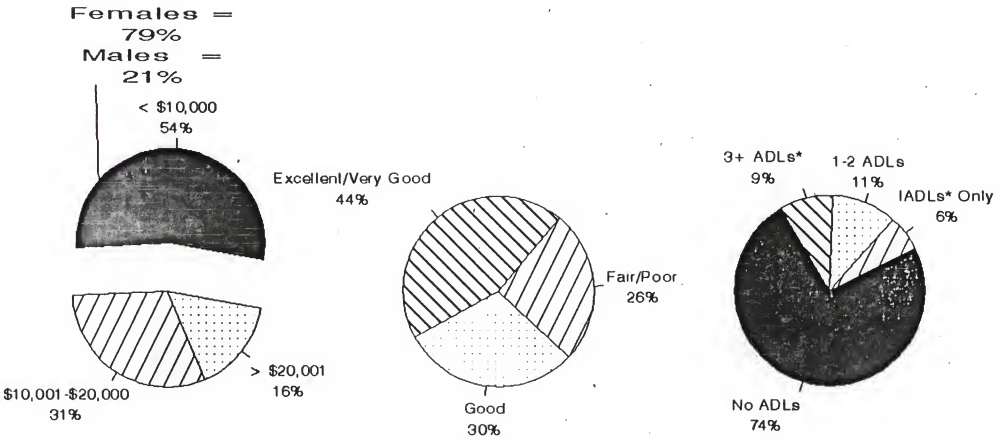


Females

Source: HCFA/OACT: Medicare Current Beneficiary Survey, 1992

Chart P-7

Medicare Beneficiaries Who Live Alone



Income

Perceived Health Status

Functional Status

Total Beneficiaries Who Live Alone = 9.7 Million

* ADL= Limitation in Activities of Daily Living (eg, eating, toileting, dressing)
* IADL= Limitation in Instrumental Activities of Daily Living (eg, laundry, grocery shopping)

Source: HCFA/OACT: Medicare Current Beneficiary Survey, 1992

Chart P-8

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More than half of female beneficiaries over the age of 85 have three or more limitations in activities of daily living, and more than one-third live alone.

- Overall, the functional status of Medicare beneficiaries decreases with age. The vast majority (85%) of beneficiaries between the ages of 65 and 74 have no limitations in activities of daily living, and only about 6% have three or more limitations. However, nearly 46% of those over the age of 85 have three or more limitations in activities of daily living.

- Female Medicare beneficiaries have greater limitations in functional status than male beneficiaries. In addition, the disparity in functional status between males and females becomes larger as they get older: over 50% of females over age 85 have three or more limitations in activities of daily living, compared to only 34% of males over age 85 (Chart P-9).

Distribution of Elderly Medicare Beneficiaries
by Gender, Age, & Functional Status, 1992

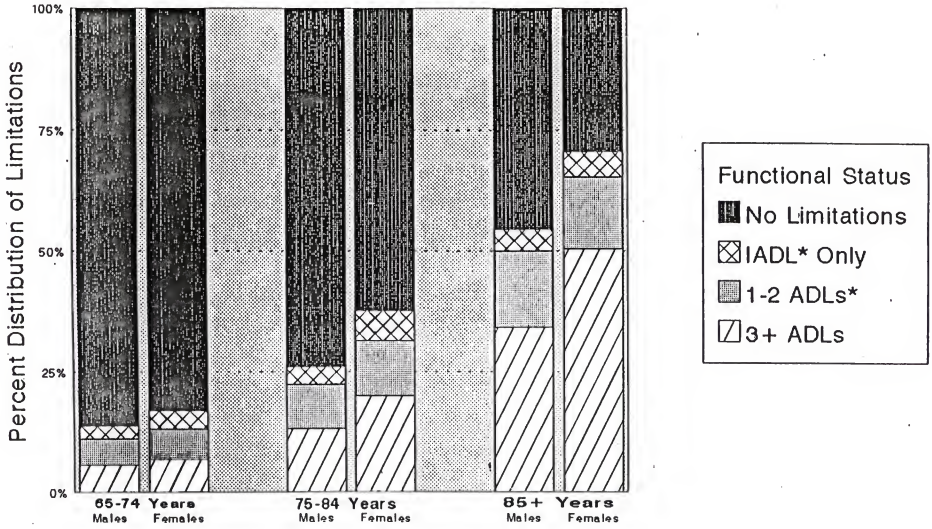


Chart P-9

* ADL = Limitation in activities of daily living (eg, eating, toileting, dressing)
* IADL = Limitation in instrumental activities of daily living (eg, laundry, grocery shopping)
Source: HCFA/OACT: Medicare Current Beneficiary Survey, 1992

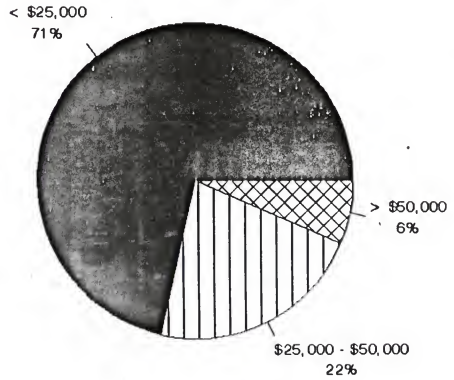
*The majority of Medicare beneficiaries have modest incomes.**

- More than three-quarters of Medicare beneficiaries reported 1992 income to be less than $25,000. Nearly 35% reported incomes of less than $10,000.

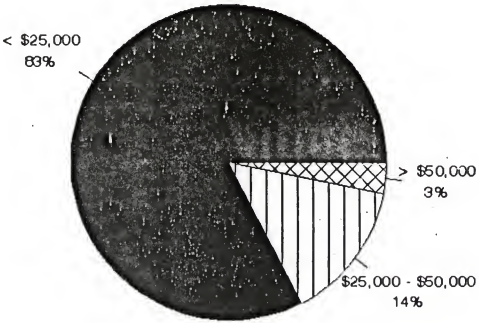
- Female beneficiaries are poorer than male beneficiaries. Eighty-three percent of females have income less than $25,000, compared to 71% of males (Chart P-10).

* Source: The Medicare Current Beneficiary Survey. Income represents gross family income, and includes pensions, Social Security, Railroad Retirement, and disability payments; the cash value of food stamps and public assistance payments; capital gains, annuities, VA and workers compensation benefits; interest, dividends, and work-related income.

Income Distribution of Medicare Beneficiaries by Gender, 1992



Males



Females

Source: HCFA/OACT: Medicare Current Beneficiary Survey, 1992

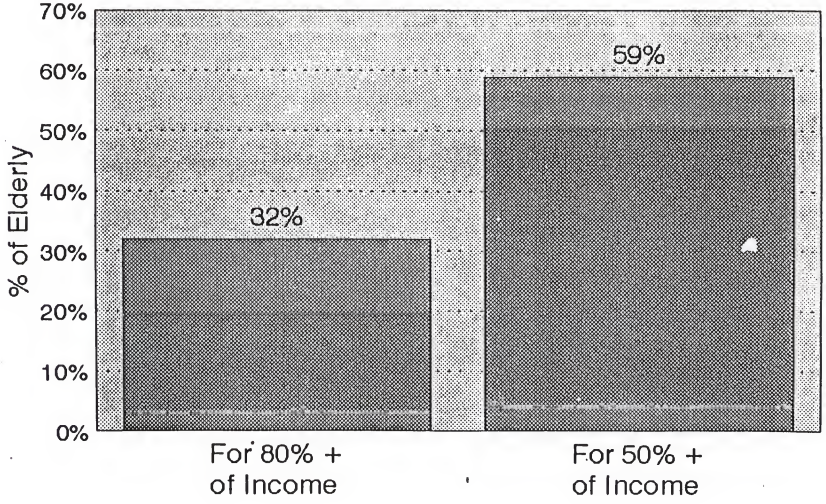
Chart P-10

Many Medicare beneficiaries depend on their Social Security benefits for much of their income.

- About *60%* of the elderly rely on Social Security benefits for *50%* or more of their income (Chart P-11).
- *Thirty-two percent* of the elderly rely on Social Security benefits for *80%* or more of their income.
- The reliance on Social Security income is greater among single elderly individuals, and increases dramatically as individuals age. Nearly 70% of those 75 years and older rely on Social Security benefits for over 50% of their income.

Source: *Income of Population 55 Years or Older, 1992*; Social Security Administration, Office of Research & Statistics, May 1994. SSA Publication #13-11871.

Percent of Elderly Relying on Social Security
1992



Source: Income of the Population, 55 Years or Older, 1992, SSA, Office of Research & Statistics

Chart P-11

Beneficiary Satisfaction

- Medicare beneficiaries are generally satisfied with the overall quality of medical care they receive: in 1992, 89% of elderly beneficiaries living in the community reported they were very satisfied or satisfied with the quality of care. Approximately 72% reported being very satisfied or satisfied with the out-of-pocket costs they paid for medical care (Chart P-12).

In a recent survey, most beneficiaries reported the program is understandable and that they are able to get general Medicare information when they need it.

- 75% of beneficiaries find Medicare understandable
- 72% said they could get information about Medicare when needed

Most beneficiaries expressed satisfaction with, although some lacked understanding of, claims processing. And most who called their carriers were satisfied with services.

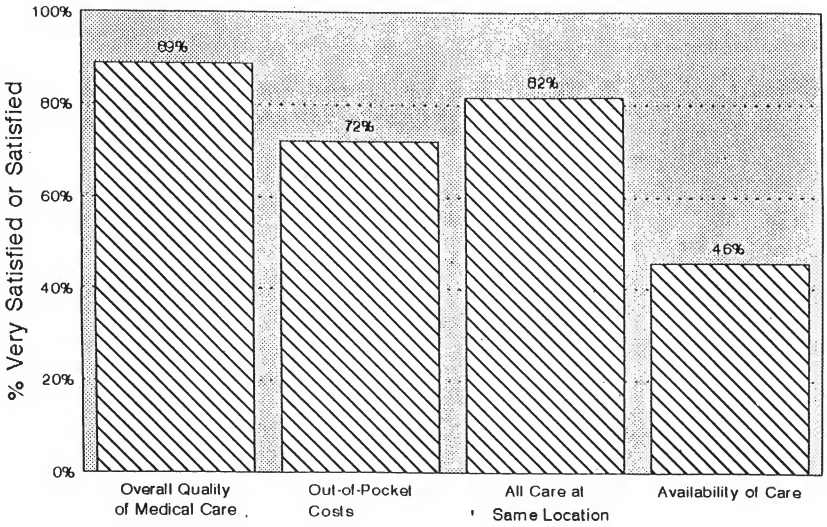
- 83% were at least generally satisfied with the way claims are processed.
- 74% of those who called carriers were at least generally satisfied.

A recent Kaiser Foundation analysis of focus groups established to identify shortcomings in the Medicare program found that seniors have 'care without worries' and 'peace of mind' because of Medicare.

- The good points of Medicare as identified by the focus groups include that the program is affordable; provides secure health care for most; offers easy, automatic enrollment; and offers coverage of 80% of many medical costs.

Sources: Medicare Current Beneficiary Survey, 1992; OIG survey, 1993; Kaiser Family Foundation Report, 1994

Beneficiary Satisfaction



Elderly in the community.

Source: HCFA/OACT: Medicare Current Beneficiary Survey, 1992

Chart P-12

PROGRAM SPENDING

HIGHLIGHTS

- In FY 1993, Medicare outlays were $143 billion.
- In recent years, Medicare skilled nursing facility and home health expenditures have grown substantially faster than hospital and physician expenditures. Hospital and physician payment reforms have moderated growth in these two key areas.
- Since 1984, Medicare expenditures per enrollee have grown at substantially slower rates than private sector expenditures. From 1976-1984 Medicare expenditures grew 14.2% annually and the private sector grew 14%; from 1984-1993 Medicare grew 7.7% while private health insurance grew 9.8%.
- Medicare's administrative costs are less than 2% of total program expenses, compared to 25% for the small group market and 5.5% for the large group market.
- The majority of Medicare spending is for beneficiaries with modest incomes: 60% of program spending is on behalf of those with incomes less than $15,000; 83% of program spending is on behalf of those with incomes of less than $25,000.

In FY 1993, Medicare outlays were $143 billion.

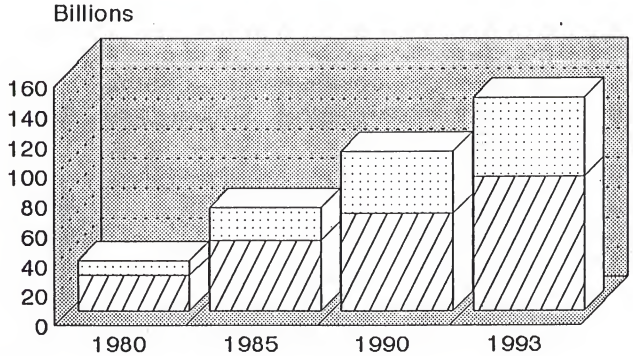
- Medicare spending grew from $34 billion in FY1980 to $143 billion in FY1993 (Chart PS-1, 2).

- With the implementation of payment reforms and as medical care has moved away from inpatient to ambulatory settings, the distribution of Medicare expenditures has shifted substantially. Part B expenditures have grown as a percent of total expenditures.

- Hospital inpatient services accounted for 66% of program outlays in 1980 but only 54% in 1993. Home health expenditures grew from 1% of outlays in 1980 to 7% in 1993 and outpatient expenditures grew from 2% to 8%. Physician/suppliers and SNF outlays have remained relatively constant as a percent of total outlays (Chart PS-3).

- In 1990 and 1993, SNF and home health outlays grew faster than in earlier years. SNF outlays grew 0.4% in 1985 compared to 40.6% in 1993. Home health outlays grew 11.2% in 1985 versus 37.8% in 1993 (Chart PS-4).

Medicare Benefit Outlays
For 35.7 Million Enrollees



Part B	10.144	21.808	41.452	52.398
Part A	23.776	47.71	65.721	90.535
Total Medicare	33.92	69.518	107.173	142.934

Total Medicare outlays increased 10.6% in 1993.

Source: HCFA/Division of Budget

Chart PS-1

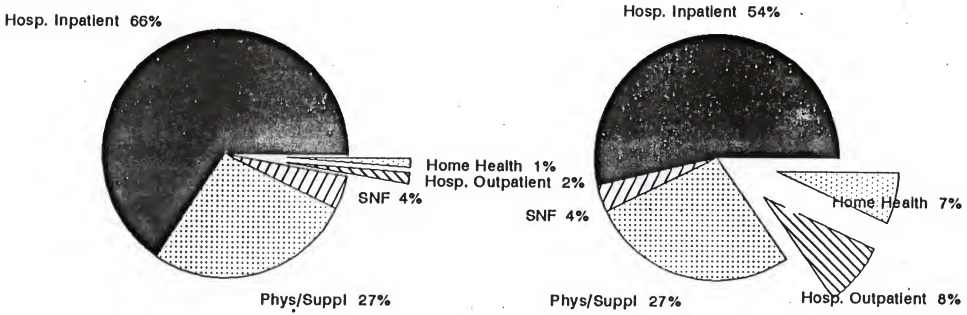
Medicare Benefit Outlays
FY 1993

	Outlays (millions)	Increase from FY 1992
Inpatient Hospital	$75,008	8.3%
Outpatient Hospital	$11,916	11.6%
Physician	$33,800	4.5%
Skilled Nursing Facility	$5,037	40.6%
Home Health (Part A only)	$9,532	37.8%
TOTAL OUTLAYS	$142,934	10.6%

Source: HCFA/Division of Budget

Chart PS-2

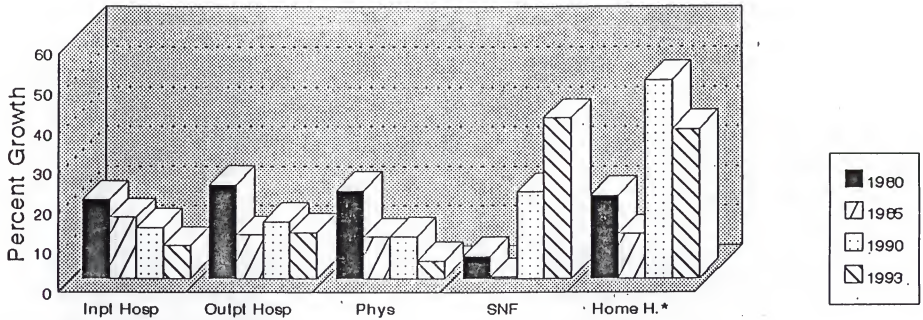
Where the Medicare Dollar Goes



Source: HCFA/OACT

Chart PS-3

Annual Growth in Medicare Outlays
Select Years



1980	19.9	23.7	22.2	5.7	21
1985	15.4	11	10.5	0.4	11.2
1990	12.9	14.3	10.6	21.9	50.1
1993	8.3	11.6	4.5	40.6	37.8

*Home Health includes Part A only
Source: HCFA/Division of Budget

Chart PS-4

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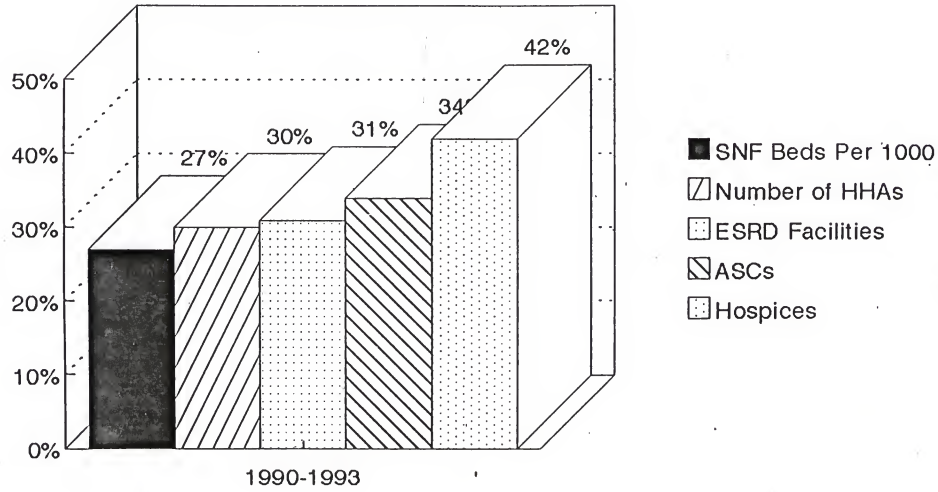
Certain categories of providers increased their participation in the Medicare program significantly over the 1980-1993 period.

- From 1980-1993, the number of participating home health agencies and hospices grew by 17% annually. Growth was even more dramatic in selected portions of that period: between 1990 and 1993, the number of ESRD facilities increased at 42% annually, and ASCs increased at 34% annually (Chart PS-5).

- Growth in home health agency and skilled nursing facility provider participation was accompanied by increased beneficiary access to and utilization of services. The number of persons served, per 1,000 enrollees, showed dramatic growth over the 1982-1992 period: 9 Medicare beneficiaries per 1,000 received SNF services in 1982, this more than doubled to 22 per 1,000 by 1992; 40 Medicare beneficiaries per 1,000 received home health services in 1982, this grew to 71 per 1,000 by 1992 (Chart PS-6).

Average Annual Percentage Growth
Medicare Non-Hospital Providers

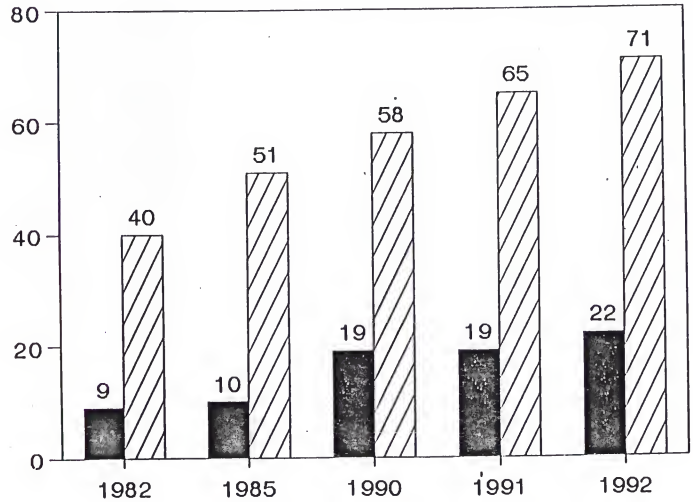


1993 Data Preliminary
Source: HCFA/BDMS and ORD

Chart PS-5

Persons Served Per 1000 Enrollees

Medicare SNF and HHA



Source: HCFA/BDMS and ORD

Chart PS-6

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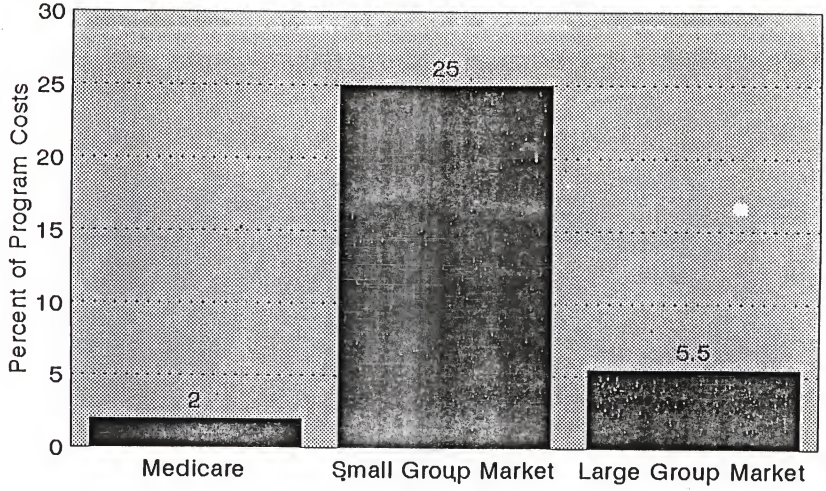
Medicare's administrative costs are considerably less than the average in the private sector.

- Medicare's administrative costs are *less than 2%* of total program expenses. Even in the large group market more than twice that amount is spent for administration (Chart PS-7). In the small group market, administrative expenses are as high as 40% for firms with less than 5 employees.

- Medicare's low administrative costs reflect both economies of scale and efficiency, through high levels of automated claims and electronic data transmission.

- Ninety percent of claims from institutional providers such as hospitals and skilled nursing facilitiies and two-thirds of claims from physicians, independent laboratories and durable medical equipment suppliers are submitted electronically to Medicare. In contrast, 60% of hospital claims and 20% of physician claims are electronically submitted to Blue Cross and Blue Shield Plans. For commercial insurers, only 10% for each category of claims are submitted electronically (Chart PS-8).

Administrative Costs
Medicare vs. Private Plans

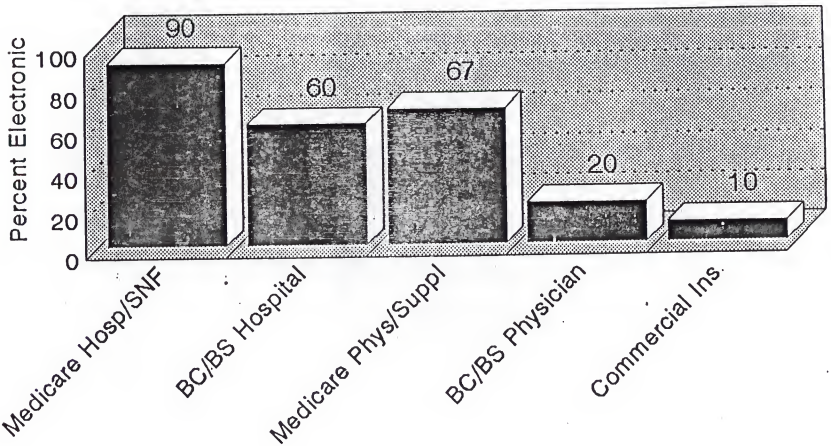


Small group market = firms <50 employees; Large group market = firms 10,000+ employees
Sources: HCFA/OACT and CRS, "Costs and Effects of Extending Health Insurance Coverage," 1988

Chart PS-7

Electronic Submission of Claims

Medicare vs. Private Insurance



1994

Sources: HCFA/BPO; Blue Cross Assoc.

Chart PS-8

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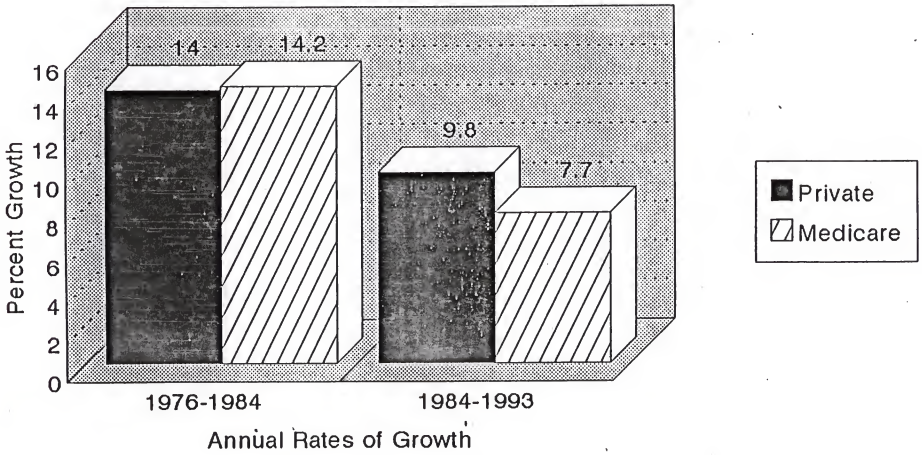
After Medicare payment reforms, beginning in 1984, Medicare expenditures have grown at slower rates than private health insurance expenditures.

- Payment reforms included prospective payment for hospitals and a fee schedule for physicians (Chart PS-9,10).

Comparison of Growth in Expenditures

Per Enrollee

Private Health Insurance vs. Medicare



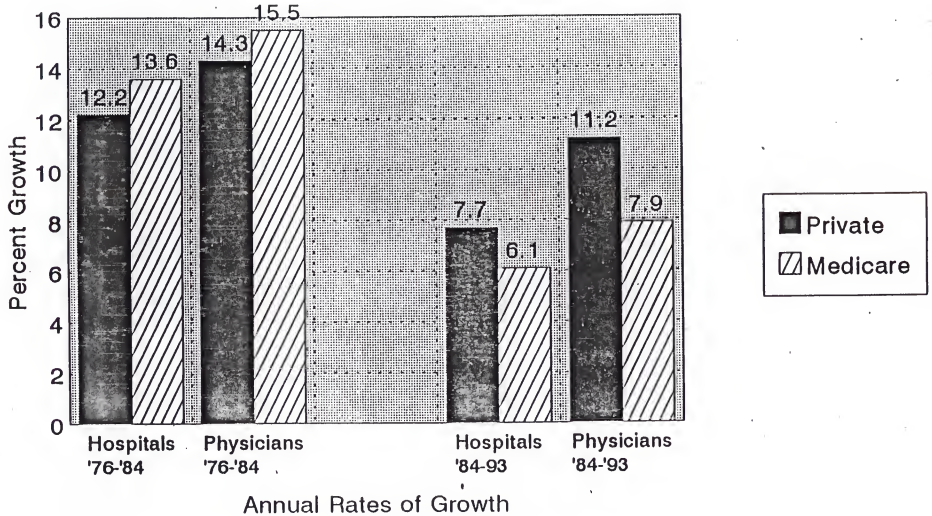
Source: HCFA/OACT

Chart PS-9

Comparison of Growth in Hospital and Physician Expenditures

Per Enrollee

Private Health Insurance vs. Medicare



Source: HCFA/OACT

Chart PS-10

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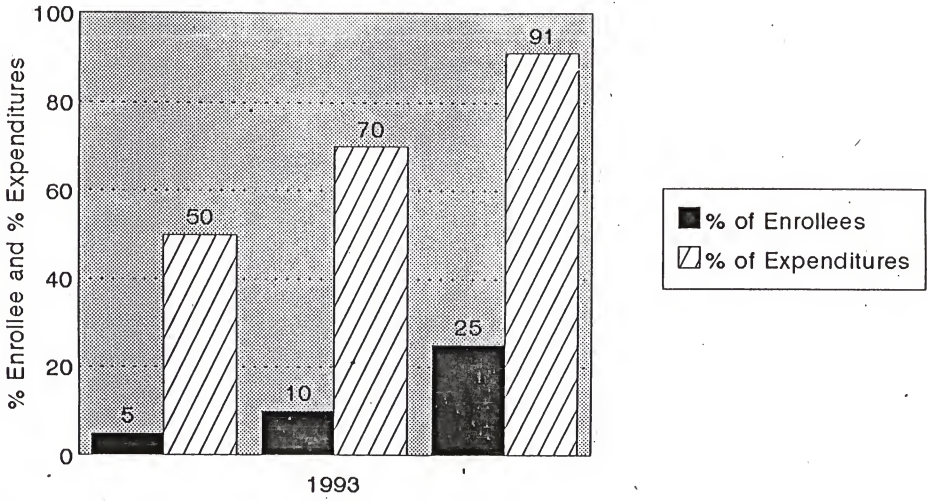
Medicare spending per enrollee is not equivalent - a small percentage of enrollees account for a large proportion of program expenditures.

- Health spending in the Medicare program is concentrated on a relatively small percentage of very sick beneficiaries. Five percent of enrollees account for 50% of expenditures; 10% of enrollees account for 70% of expenditures; and 25% of enrollees account for 91% of expenditures (Chart PS-11).

- Certain classes of beneficiaries also account for a disproportionate share of Medicare expenditures. While only about 1% of enrollees have ESRD, these enrollees accounted for 5% of total program expenditures (1992). In 1992, 6% of beneficiaries died; 19% of total program expenditures are attributable to this last year of life (Chart PS-12).

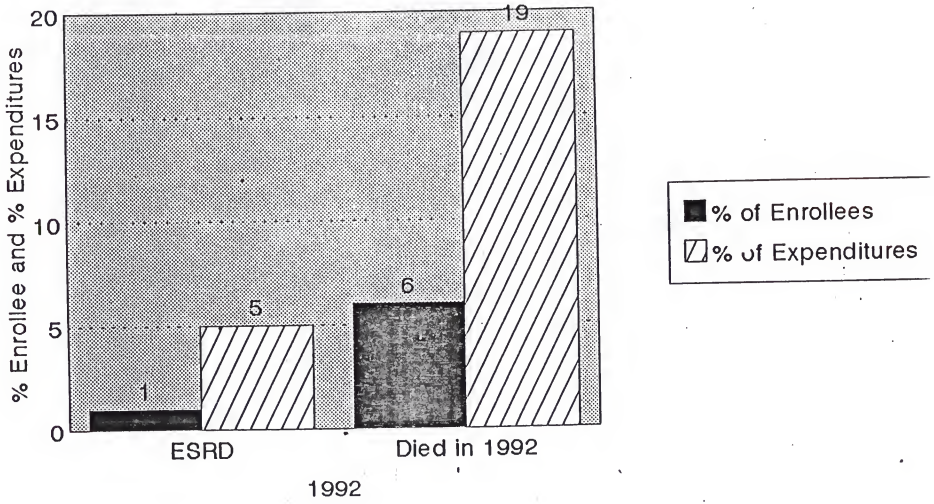
Distribution of Medicare Expenditures
by Top Percentiles of Enrollees



Source: HCFA/OACT

Chart PS-11

Distribution of Medicare Expenditures
by ESRD and by Mortality



Source: HCFA/OACT

Chart PS-12

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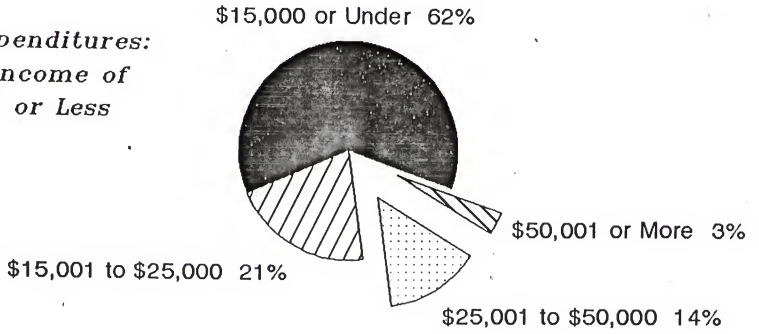
Medicare spending is primarily for beneficiaries with modest incomes.

- The majority of Medicare spending is for beneficiaries with modest incomes: 60% of program spending is on behalf of those with incomes less than $15,000; 83% of program spending is on behalf of those with incomes of less than $25,000 (Chart PS-13).

Share of Program Expenditures by Income
Of Medicare Individuals or Couples, 1992

83% of Expenditures: Annual Income of $25,000 or Less



Excludes 2.2% not reporting income. Also excludes HMO enrollees (9%).
Source: HCFA/OACT

Chart PS-13

HEALTH SPENDING FOR THE ELDERLY

HIGHLIGHTS

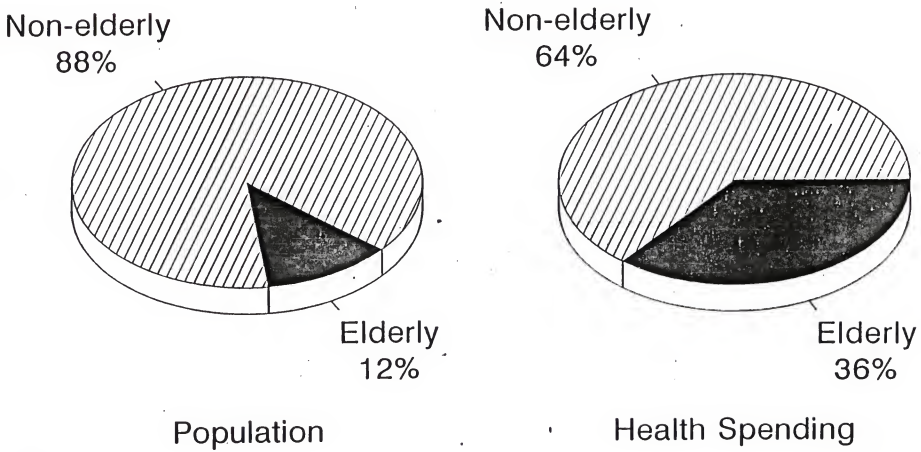
- Although only 12% of the population, the elderly account for 36% of national health spending. Per capita health spending for the elderly is 4 times higher than for under 65 population.
- Medicare covers 45% of the total health bill for the nation's elderly, private sources pay 37%, Medicaid pays 12%, and other public sources pay 6%.
- The vast majority of elderly Medicare beneficiaries have insurance to supplemental Medicare; its source varies significantly by sex, race, age, and income.
- Beneficiaries in poor health are less likely to have supplemental insurance coverage than those in excellent health.
- Less than half of the near poor (those with family incomes between 100 - 150% of the Federal poverty level) have insurance coverage for outpatient prescription drugs. More than two-fifths of all beneficiaries have no coverage. Those purchasing outpatient prescription drugs with no insurance paid an average of $433 out-of-pocket in 1992.
- Out-of-pocket payments by the elderly covered half of all nursing home expenses in 1992.

The elderly account for a disproportionate share of national health spending.

- While 12% of the population, in 1987 the elderly accounted for 36% of national health spending (Chart H-1).
- The share of health spending on the elderly in even larger; they account for 90% of nursing home spending.
- National per capita health spending in 1987 was $1,776 for all Americans; $1,286 for the under 65; and $5,360 for the elderly. Health spending for an elderly person was 4 times that for a person under age 65.

Health Spending for the Elderly, 1987

Share of National Totals



Source: "Health expenditures by age group, 1977 and 1987," Health Care Financing Review/Summer 1989

Chart H-1

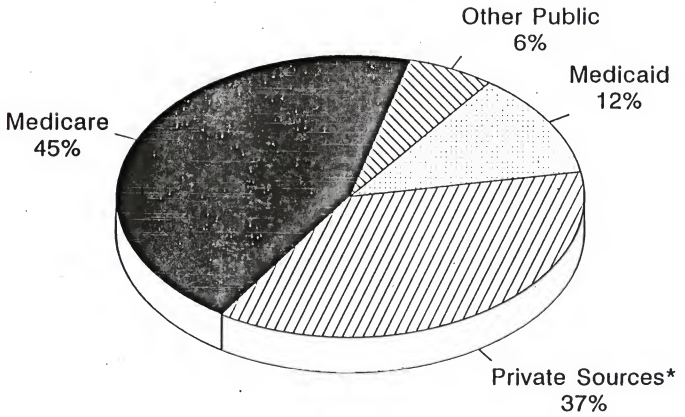
Health spending for the elderly.

- The single largest payer of health services for the elderly is the Medicare program at 45%; private sources pay 37% primarily out-of-pocket payments by the elderly for Medicare cost-sharing and non-covered services like long term nursing home care as well as private insurance which supplements Medicare cost-sharing; Medicaid pays 12% for the dually entitled elderly; and 6% is paid by other public sources (Chart H-2).

- Medicare's share of the elderly's health spending decreases from 50% to 35% as age increases, primarily because utilization of long term nursing home care, which Medicare does not cover to any significant extent, increases with age.

Health Spending for the Elderly, 1987

Who Pays the Bill?



* Includes supplemental insurance, beneficiary direct payments, and philanthropy.

Source: "Health expenditures by age group, 1977 and 1987," Health Care Financing Review/Summer 1989

Chart H-2

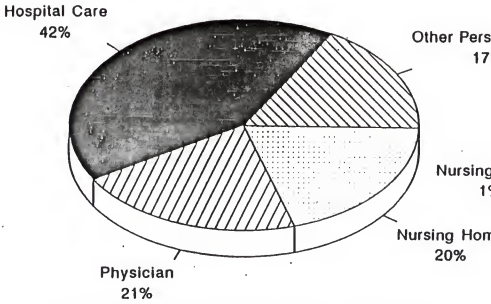
National health spending for the elderly by type of service, total and Medicare.

- Total health spending for the elderly is primarily spent on hospital care at 42%, physicians services at 21%, nursing home services at 20%, and other personal health care such as outpatient prescription drugs at 17% (Chart H-3).

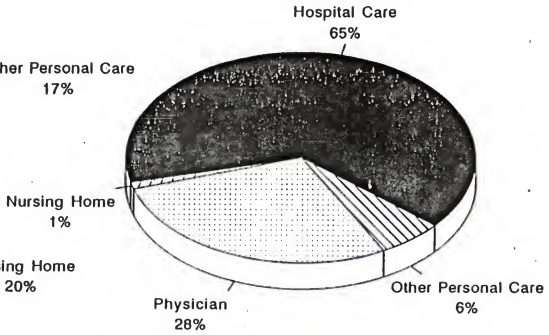
- Medicare spending by type of service does not closely mirror total health spending for the elderly because Medicare primarily covers acute health conditions. For example, chronic conditions which require long term placement in a nursing home are not covered by Medicare (Chart H-3).

- Reflecting Medicare's relatively generous coverage of acute services, 65% of the Medicare dollar is spent on hospital care; 28% on physicians; less than 1% on nursing home care; and 6% on other personal health care (Chart H-3).

Health Spending for the Elderly, 1987
Expenditure Comparison



Distribution of Total Expenditures



Distribution of Medicare Expenditures

Source: "Health expenditures by age group, 1977 and 1987," Health Care Financing Review/Summer 1989

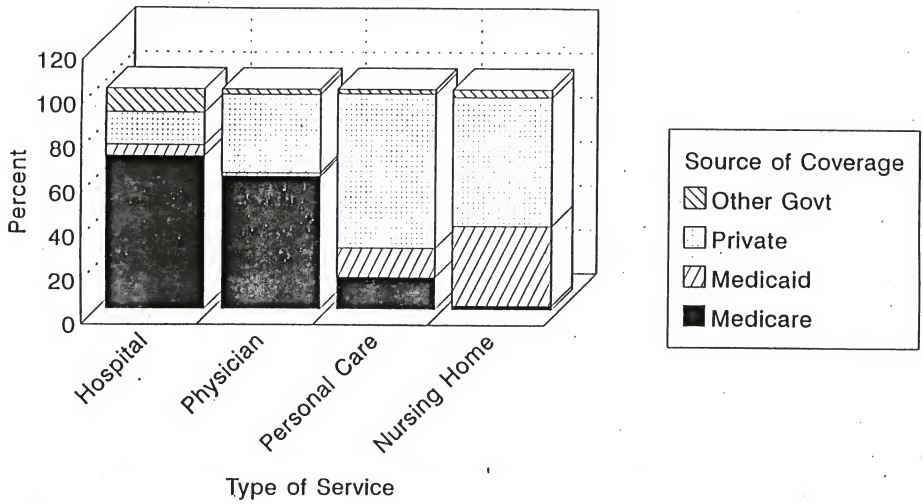
Chart H-3

The payment source varies significantly by type of service: Medicare pays the majority of the elderly's hospital bill, private sources pay the majority of the nursing home bill and other personal health care.

- Medicare pays 70% of the elderly's hospital bill, 61% of physician services, 15% of other personal health care, and less than 2% of the nursing home bill (Chart H-4).
- Medicaid pays 5% of the elderly's hospital bill, 2% of physician services, 13% of other personal care, and 36% of the nursing home bill (Chart H-4).
- Private sources pay 15% of the elderly's hospital bill, 36% of physician services, 70% of other personal care, and 58% of the nursing home bill (Chart H-4).

Health Spending for the Elderly

What Percent Does Medicare Pay?



Source: "Health expenditures by age group, 1977 and 1987," Health Care Financing Review/Summer 1989

Chart H-4

The vast majority of elderly Medicare beneficiaries also have other sources of insurance coverage.

- Medicare pays 83% of the cost of services that it covers. The remaining 17% is the cost-sharing obligation of beneficiaries. To meet these and other health expenses not covered by Medicare, many beneficiaries have supplemental insurance coverage.

- The vast majority (89%) of elderly Medicare beneficiaries have other coverage to supplement Medicare: 36.8% have Medigap insurance that they individually purchased, 33.0% receive Medigap coverage from a former employer, 11.9% qualify for Medicaid, 2.0% receive additional coverage from other sources, 11.4% have no supplemental coverage (Chart H-5).

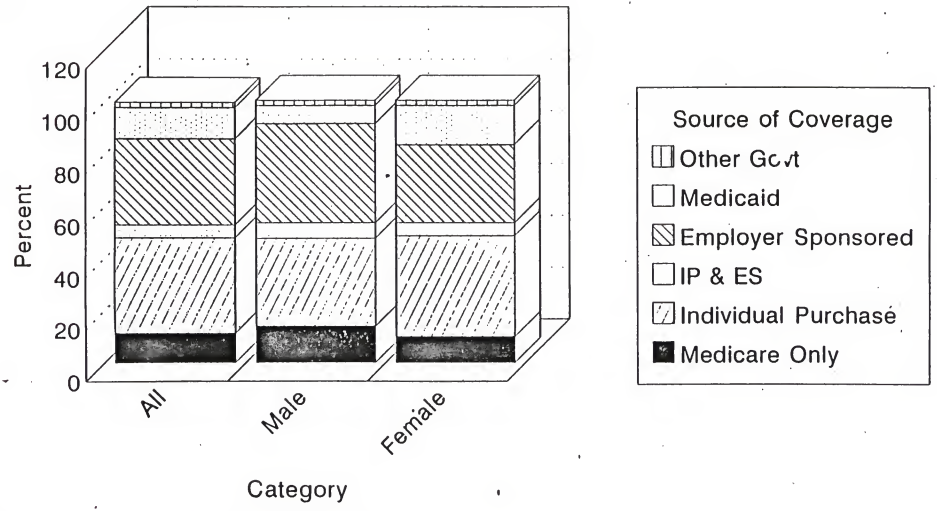
- The average cost of a Medigap plan in 1992 was about $840, varying by geographic location, age, disability and level of benefits.

- Medigap insurance varies in the level of coverage. Some plans fill in Medicare cost-sharing while others cover Medicare cost-sharing and additional services such as outpatient prescription drugs.

- Males are more likely than females to have Medicare as their only coverage. Males are more likely to have employer sponsored supplements. Females are more likely to individually purchase coverage. Females are twice as likely as males to be Medicaid-eligible. (Chart H-5)

Insurance Holdings of Aged Medicare Beneficiaries

Source by Sex



*Individual Purchase (IP) and Employer Sponsored (ES)

Source: "Health Insurance and the Elderly: Data from MCBS," Health Care Financing Review/Spring 1993

Chart H-5

Supplemental coverage patterns vary significantly by race.

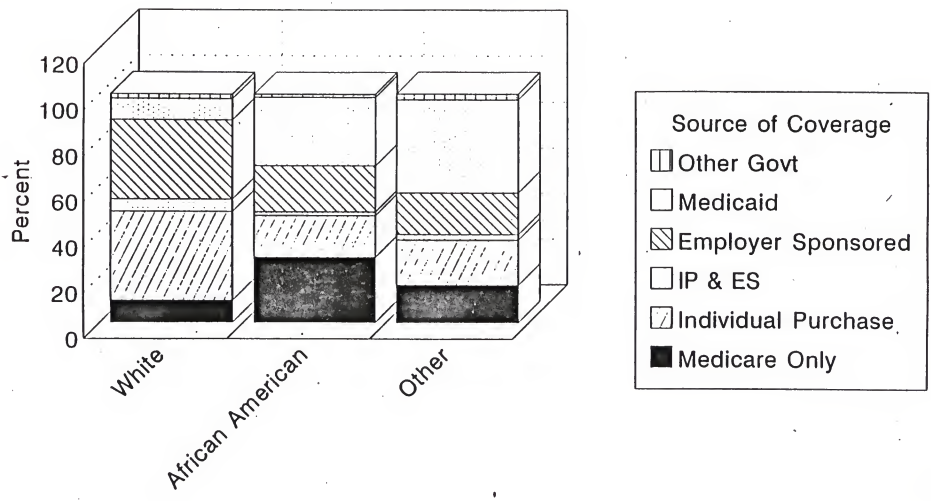
- Nearly three-fifths of elderly African-Americans have no supplemental coverage or rely on Medicaid to fill in. They are three times as likely as whites to only have Medicare, and three times as likely to have Medicaid (Chart H-6).

- The share of the elderly with private Medigap insurance is nearly twice as high for whites as for blacks, and for those of other races.

- The elderly of other races, including Hispanics, are 1.5 times as likely as whites to only have Medicare, but are four times as likely to have Medicaid.

Insurance Holdings of Aged Medicare Beneficiaries

Source by Race



Percent of Medicare Beneficiaries: White (88.9%), African American (7.9%), Other (3.2%)
Source: "Health Insurance and the Elderly: Data from MCBS," Health Care Financing Review/Spring 1993

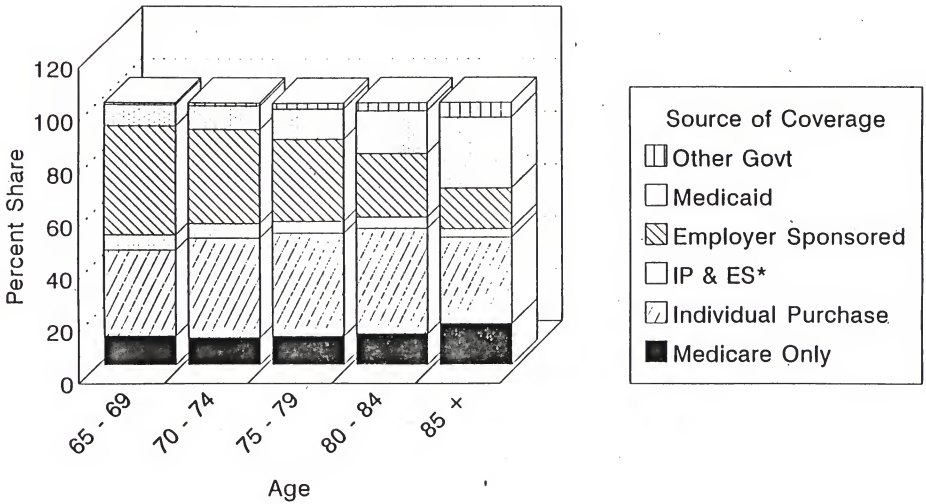
Chart H-6

Supplemental coverage patterns are different by age group.

- Beneficiaries 85 years and over are much more likely to have Medicare as their only coverage (Chart H-7).
- Employer sponsored coverage declines steadily with advancing age.
- Medicaid eligibility increases with advancing age.

Insurance Holdings of Aged Medicare Beneficiaries

Percent Share by Age



*Individual Purchase (IP) and Employer Sponsored (ES)

Source: "Health Insurance and the Elderly: Data from MCBS," Health Care Financing Review/Spring 1993

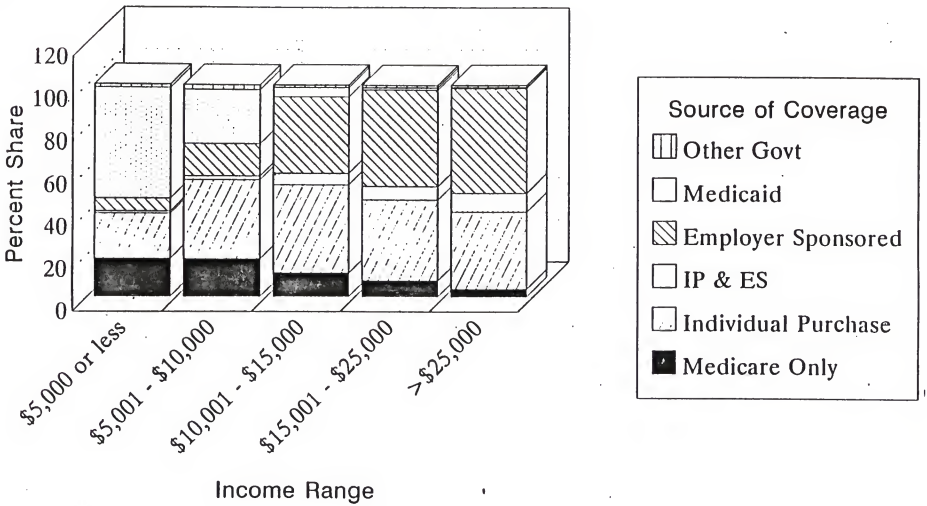
Chart H-7

The source of supplemental coverage is correlated with income.

- 11.9% of Medicare enrollees' incomes are low enough to also qualify for Medicaid
- Those in the highest income categories are much more likely to have employer sponsored supplements (Chart H-8).
- The share of Medicare beneficiaries who purchase private individual insurance is one and a half to two times as large for those in families with incomes above $5,000 as those below that figure.

Insurance Holdings of Aged Medicare Beneficiaries

Percent Share By Income



Source:"Why More Cost-Sharing Won't Slow Medicare Spending"
Journal of American Health Policy, July/August 1993

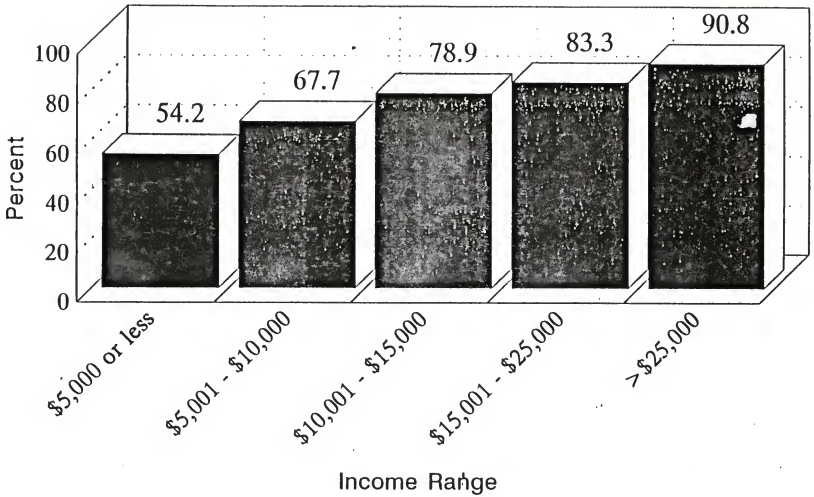
Chart H-8

Most beneficiaries obtain supplemental coverage, even low-income individuals who must purchase it themselves.

- Of the Medicare beneficiaries who purchase Medigap insurance directly, (that is, they do not have Medicaid or an employer sponsored supplement)(Chart H-9):
  - Slightly more than half of those with incomes below $5,000,
  - Nearly 70% with incomes between $5,000 and $10,000, and
  - About 80% - 90% of those with higher incomes.

Percent of Medicare Beneficiaries Who Buy Supplemental Coverage Without Employer or Government Support

By Income



Source: "Why More Cost-Sharing Won't Slow Medicare Spending"
Journal of American Health Policy, July/August 1993

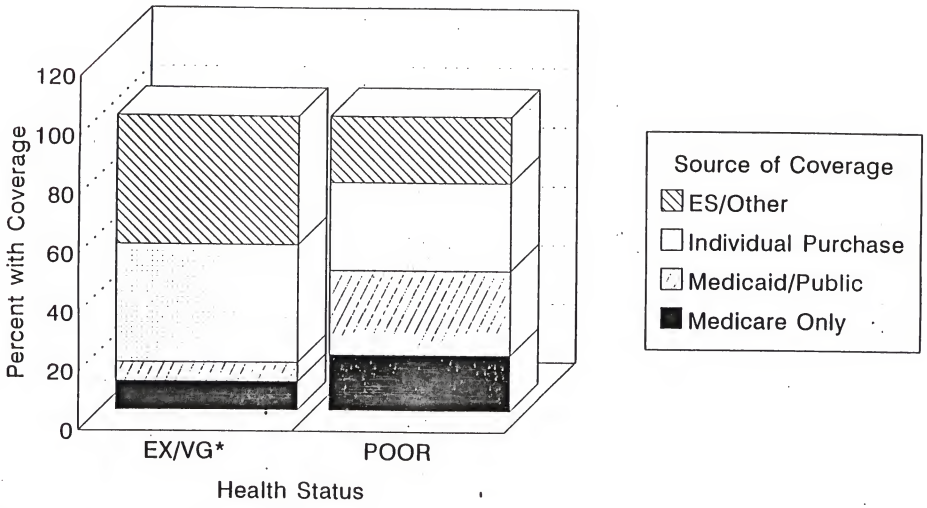
Chart H-9

Those with perceived ill health have less insurance coverage than those in better health.

- *Twice as many* elderly who report they are in poor health, compared to their peers, have only Medicare coverage - no supplemental coverage -compared to those in excellent or very good health (Chart H-10).

- Those in poor health are *less likely* to individually purchase or to have employer paid Medigap than those in excellent health (Chart H-10).

Insurance Holdings of Aged Medicare Beneficiaries
By Self-Assessed Health Status



* Health Status: Excellent (EX) and Very Good (VG)

Source: "Health Insurance and the Elderly: Data from MCBS," Health Care Financing Review/Spring 1993

Chart H-10

Medicare does not cover outpatient prescription drugs, and more than 40% of Medicare beneficiaries have no insurance coverage for outpatient prescription drugs. Coverage varies by income.

- Forty percent of persons living below poverty have no drug coverage from any source. The remainder have coverage through Medicaid, other public programs or private insurance. For those beneficiaries living just above the poverty level (between 100-150% of poverty) the percent with drug coverage shrinks substantially - less than half have any third-party coverage for prescription drugs. (Chart H-11)

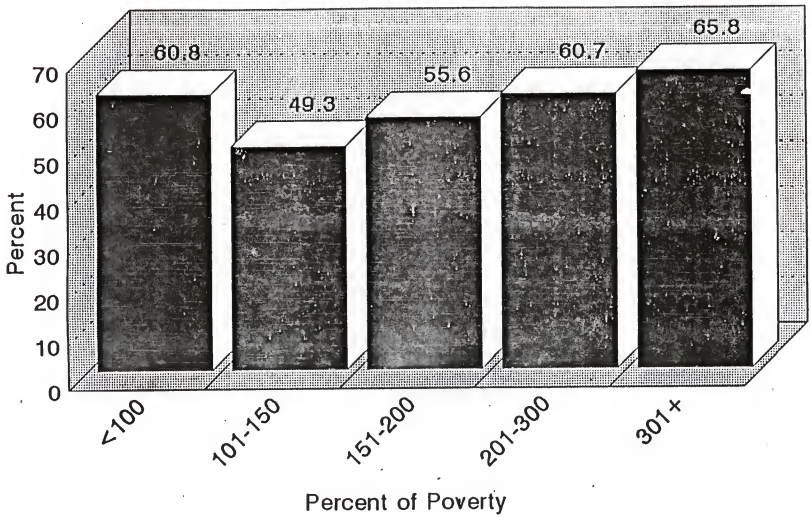
- Even for persons with incomes 3 times the poverty level, one-third are without any private or public drug coverage.

- In 1992, the 86% of beneficiaries who purchased prescriptions, whether with any third-party coverage (private, Medicaid, etc.) or out-of-pocket, spending averaged $572. For those who purchased prescriptions with no third-party coverage, the out-of-pocket expenses averaged $433. (Source: HCFA/OACT, unpublished paper, 1994).

- The elderly pay 56% of their outpatient prescription drug expenses out-of-pocket, private insurance pays 25%, Medicaid pays 12% and the Veterans Administration and other public programs pay 7% (Chart H-12).

Prescription Drug Coverage by Relation to Poverty Level

Medicare Beneficiaries

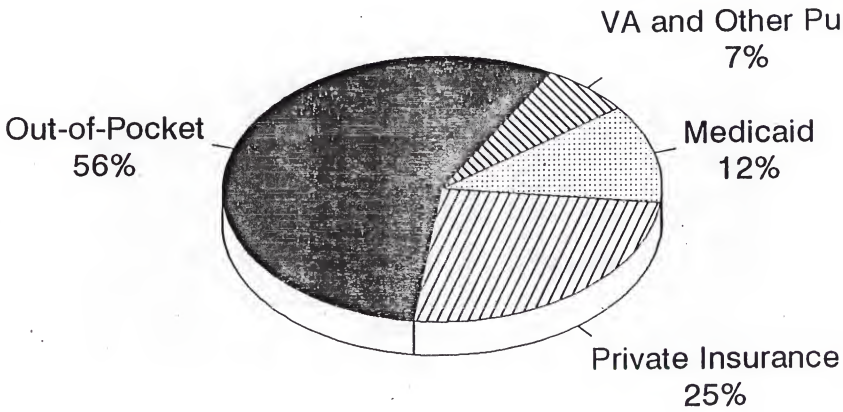


Source: HCFA/OACT

Chart H-11

What share do the elderly pay?

Prescription Drugs



Source: HCFA/OACT

Chart H-12

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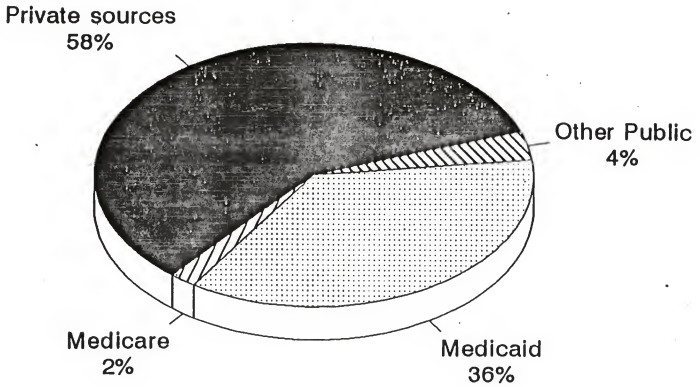
Medicare does not cover long term nursing home care. Private sources, primarily directly out-of-pocket, paid over half of all nursing home expenses.

- Medicaid is the single largest insurer of nursing home care for the elderly at 36% of the total bill. Medicare covered only 2% of nursing home expenses -- for short term stays (Chart II-13).

- Only 17 percent of all beneficiaries have any private insurance coverage for nursing home services. For those with incomes over $25,000, 23 percent have such coverage.

What share do the elderly pay?
Nursing Home Expenses



1992

Source: HCFA/OACT

Chart H-13

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Access To Care

HIGHLIGHTS

- Medicare physician payment reform did not create new barriers in access to care for vulnerable populations. Overall physician visits increased after implementation of the fee schedule.

- The percent of Medicare expenditures paid on assignment (those for which the provider accepts the amount Medicare approved as total payment) is continuing to increase, with the assignment rate reaching 96% in 1993.

- Medicare beneficiaries without supplemental insurance policies have had fewer physician visits than those with supplemental policies, even though survey data shows that persons without supplemental policies tend to have greater limitations in functional status and are therefore presumably more in need of care.

- Both Medicaid-eligible Medicare beneficiaries ("dually-eligible") and very elderly beneficiaries had an avoidable hospitalization rate more than double that of the total population of Medicare beneficiaries.

- Female Medicaid-eligible beneficiaries, those living in poverty areas, African-Americans, and those over the age of 85 had lower rates of use of mammograms and Pap tests than female Medicare beneficiaries overall. Preliminary data shows that African-American beneficiaries are being immunized with influenza vaccine at less,than half the rate of white beneficiaries.

Access To Care

Medicare policies governing physician payment reform did not create new barriers to care for vulnerable populations; however, existing barriers to care for many populations persist.

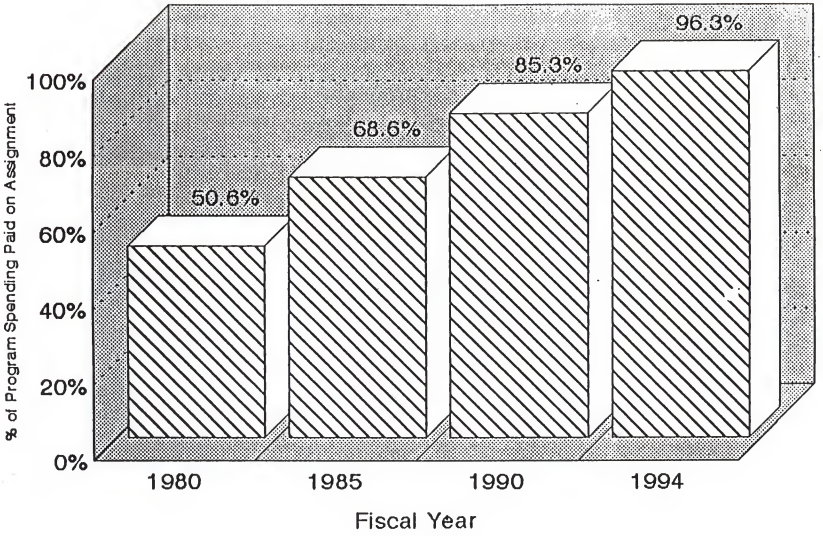
- A recent report to Congress from the U.S. Department of Health and Human Services, *Monitoring the Impact of Medicare Physician Payment Reform on Utilization and Access* (1994), showed that OBRA 1989, which mandated physician payment reform under Medicare, did not create new barriers to care for vulnerable populations. However, there are clear indications that many population groups continue to face barriers to care.

- Further evidence of the adequacy of access to care is suggested by the increase in assignment rate:

  - the percent of expenditures paid on assignment (those claims for which the provider agrees to accept the amount approved as total payment) continues to increase: 96% in 1994 (Chart A-1).

  - the percent of expenditures paid to participating physicians and suppliers (those who agree to accept assignment on all Medicare claims) has also risen significantly: nearly 90% of all Medicare expenditures were paid to participating physicians in 1994 (Chart A-2).

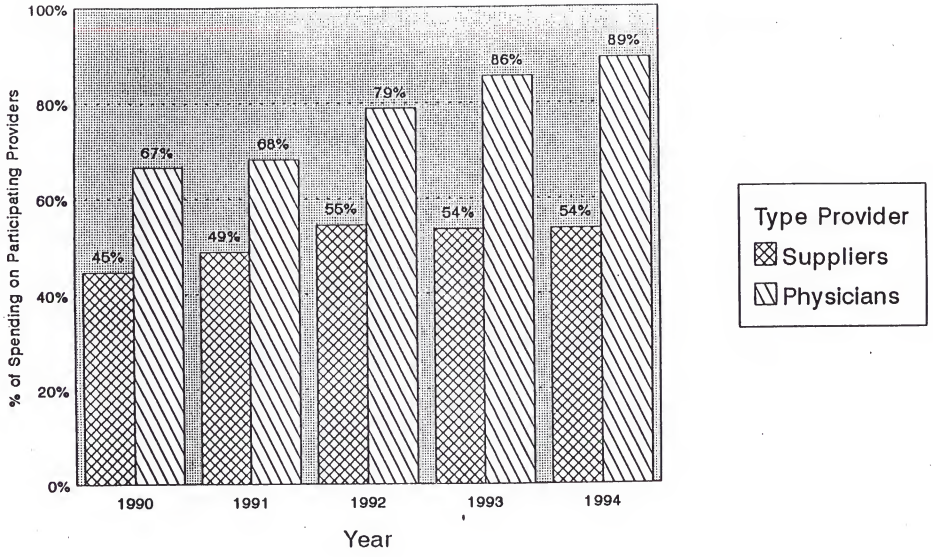
Medicare Expenditures Paid on Assignment



Source: HCFA/BPO

Chart A-1

Medicare Expenditures Paid to Participating Providers



Source: HCFA/BPO

Chart A-2

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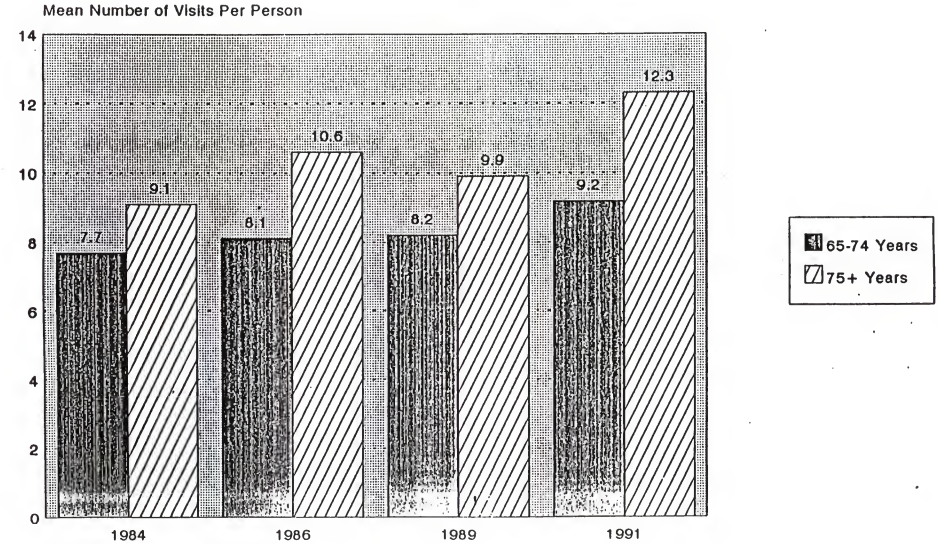
Vulnerable populations and those without supplemental insurance have fewer physician visits.

- The average number of physician visits increased after implementation of physician payment reform to 9 visits annually for those 65 to 74 years old (Chart A-3).

- One of the most important indicators of access to care is the rate of physician visits per person, because it is seen as an indicator of gaining entrance to the health care system. Recent research showed that persons residing in areas designated as health professional shortage areas, those living in poor areas, and those in rural areas tended to have lower outpatient visit rates. In addition, Medicare beneficiaries without supplemental insurance policies have had fewer physician visits than those with supplemental policies, even though survey data shows that persons without supplemental policies tend to have greater limitations in functional status and therefore are more likely to need to see a doctor.

Physician Visits Per Person, by Age



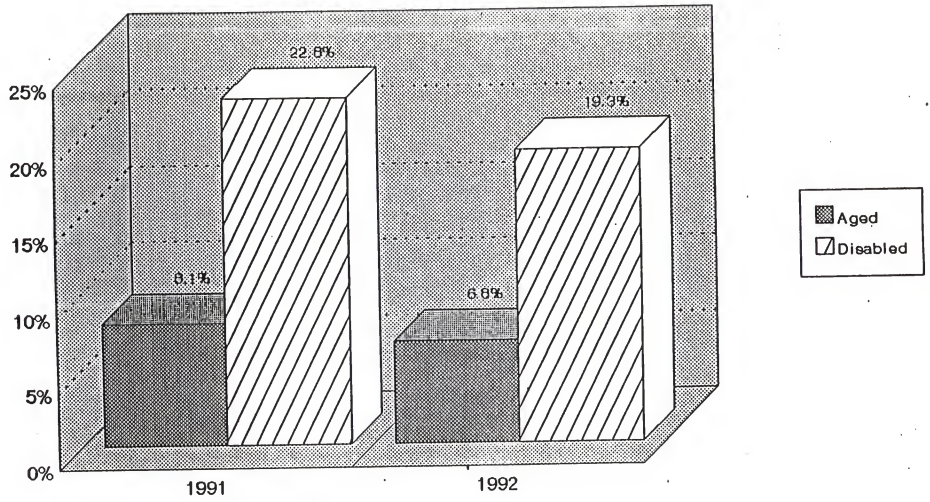
Source: Dept. of Health & Human Services: Annual Report to Congress: Monitoring the Impact of Physician Payment Reform on Utilization and Access, 1994
(Data from National Health Interview Survey, National Center for Health Statistics)

Chart A-3

The disabled often face significant barriers to care.

- Compared to the elderly, the Medicare disabled had a higher proportion of persons who reported having a health problem but not receiving care in the previous year. This is consistent with the fact that the disabled population are more likely than the aged to face greater barriers to care because of more chronic illnesses and continuing care needs (Chart A-4).

Percent of Beneficiaries Reporting a Health Problem and Not Receiving Care in Previous Year



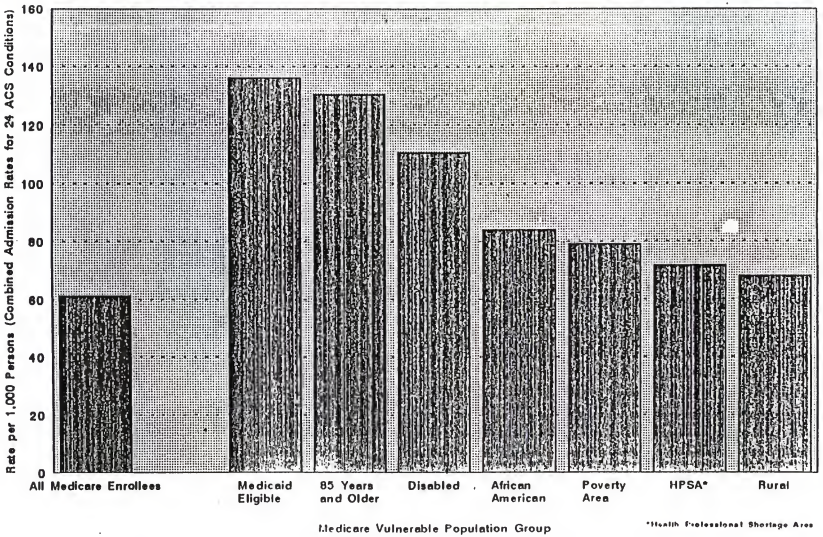
Source: HCFA/ORD: Medicare Current Beneficiary Survey, 1992

Chart A-4

The poor and the very elderly have high rates of avoidable hospitalizations.

- High rates of hospitalization for "ambulatory care sensitive" conditions such as asthma or diabetes -- conditions which are sensitive to good and continuous ambulatory care -- may be an indicator of barriers to care. Research showed that vulnerable populations of Medicare beneficiaries had higher rates of these potentially avoidable hospitalizations then Medicare beneficiaries overall. Both the Medicaid-eligible beneficiaries ("dually-eligible") and the very elderly had a potentially avoidable hospitalization rate more than double that of the total population of Medicare beneficiaries (Chart A-5).

Ambulatory Care Sensitive Admission Rates
for Medicare Beneficiaries, 1991



Source: Dept. of Health & Human Services Annual Report to Congress: Monitoring the Impact of Medicare Physician Payment Reform on Utilization and Access, 1993
(Data from Part A Claims & Denominator File for a Sample of Medicare Beneficiaries, 1991)

Chart A-5

Preventive services and access to care.

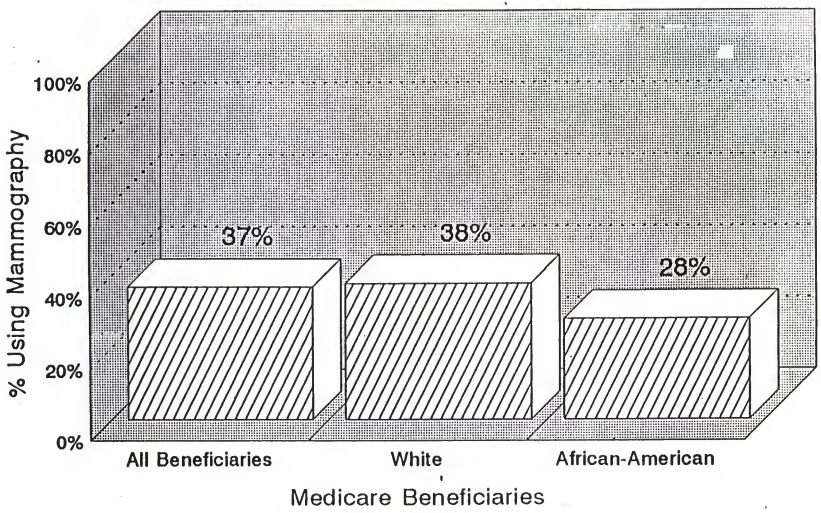
- The use of preventive services can be used to examine access to care. Medicare covers a very limited number of preventive services, including: hepatitis, pneumococcal pneumonia, and influenza vaccines; Pap tests; and screening mammography. Even though these critical preventive services are covered by Medicare, particularly vulnerable subgroups of beneficiaries often do not receive needed care.

- A recent study showed that vulnerable groups of beneficiaries, including those who are Medicaid-eligible, living in poverty areas, African-Americans, or over the age of 85, had lower rates of use of screening mammography and Pap test than Medicare beneficiaries overall (Chart A-6).

- The influenza vaccine became a covered service under Medicare in 1993. Preliminary data shows large differences in immunization rates by race, with African-American beneficiaries being immunized at less than half the rate of white beneficiaries (Chart A-7).

Source: U.S. Department of Health & Human Services (DHHS), Annual Report to Congress: Monitoring the Impact of Physician Payment Reform on Utilization and Access, 1994.

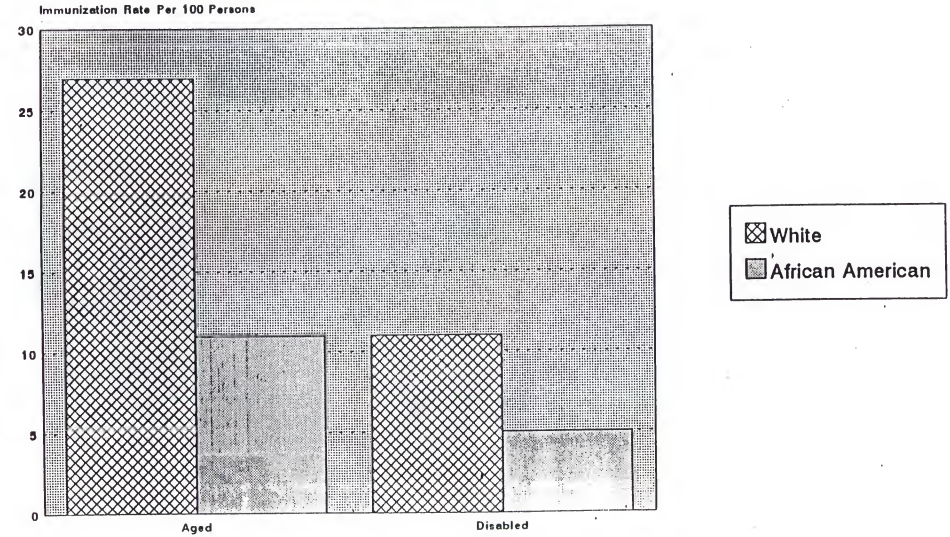
Mammography Use By Medicare Beneficiaries
1992-1993



Source: HCFA Administrative Claims Data, 1992-1993

Chart A-6

Influenza Immunization Rates for Medicare Beneficiaries by Race, 1993



Source: Dept. of Health & Human Services Annual Report to Congress: Monitoring the Impact of Medicare Physician Payment Reform on Utilization and Access, 1994
(HCFA Part B Administrative Data Through December 1993 - Preliminary Data)

Chart A-7

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Managed Care

HIGHLIGHTS

- An increasing number of HMOs have entered the Medicare market: 70% of HMOs plan to offer a Medicare managed care product.

- Medicare enrollment in risk* HMOs grew 25% between 1993 and 1994. The number of Medicare enrollees of risk HMOs--2.3 million--is still a small share, 7%, of the Medicare population.

- The majority of Medicare enrollees of HMOs incur little or no out-of-pocket expenses for HMO coverage. HMO coverage generally includes non-Medicare-covered services, such as preventive care and unlimited hospitalization. A substantial proportion of Medicare enrollees of HMOs have coverage of outpatient prescription drugs at little or no cost.

- Medicare risk* HMO enrollment is concentrated 5 states: California (nearly one million enrollees), Florida (nearly 400,000), Arizona (over 150,000), New York (nearly 105,000), and Oregon (over 100,000).

*Note: Appendix II has a more detailed discussion of the Medicare managed care program.

Medicare enrollment in managed care plans, while still small, has been growing rapidly.

- As of 1994, 74% of Medicare beneficiaries lived in areas served by a Medicare managed care plan (Chart MC-1).

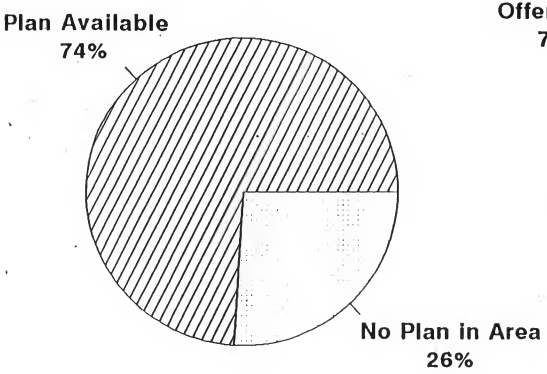
- A 1992 survey of HMOs by the Group Health Association of America (an HMO trade association) found that 40% of HMOs offered a Medicare product (risk, cost or Medicare Select). According to a 1994 survey of plans by GHAA, 70% of HMOs will continue to offer, or plan to newly offer, a Medicare managed care product (Chart MC-1).

- There are now 242 prepaid organizations (cost and risk contracts) (Chart MC-2) enrolling 3.1 million Medicare members (about 9% of all beneficiaries) (Chart MC-3). The 154 risk-contracting HMOs had 2.3 million enrollees.

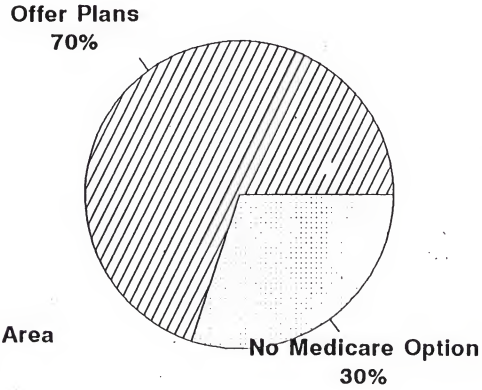
- Since 1989, the rate of growth of Medicare risk HMO enrollment has exceeded the rate of growth in HMO enrollment in the private sector (Chart MC-4). From 1993 to 1994, growth in Medicare risk HMO enrollment was 25%; enrollment growth among all HMO enrollees was slightly less than 11%.

Availability of Medicare Managed Care Products

Percent of Beneficiaries With Plans Available (1994)



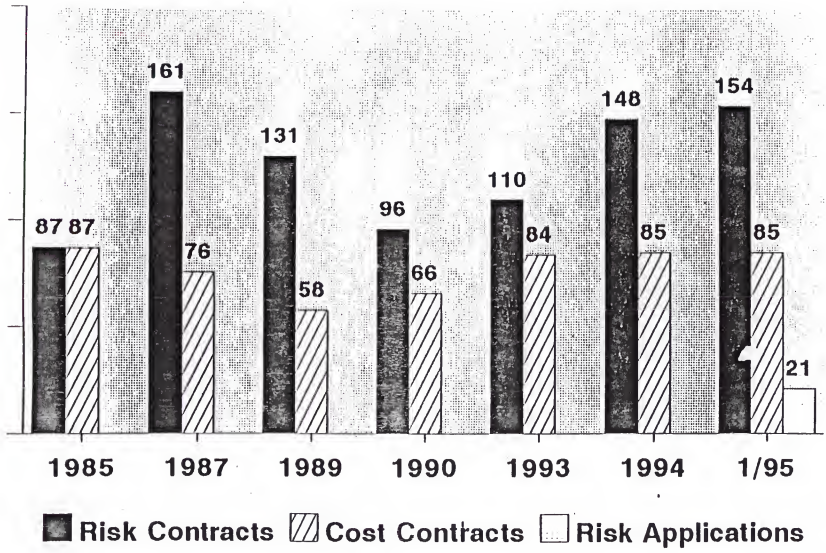
HMOs Offering a Medicare Product (1995)



Source: HCFA OMC, Group Health Association of America

Chart MC-1

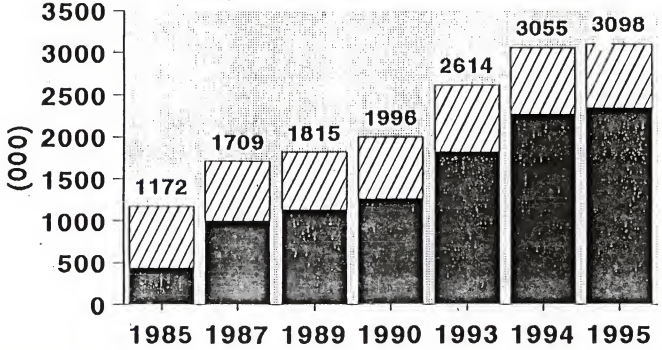
Medicare HMO Contracts, 1985 to Present



Source: HCFA OMC

Chart MC-2

Medicare HMO Enrollment, 1985 to Present
(In Thousands)



Cost HMO Enrollment	731	706	681	732	799	787	758
Risk HMO Enrollment	441	1003	1134	1264	1815	2268	2340

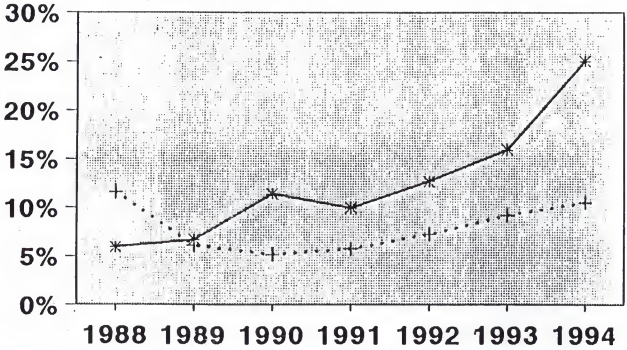
■ Risk HMO Enrollment ▨ Cost HMO Enrollment

Cost HMO Enrollment Numbers Include Cost HMOs and Health Care Prepayment Plans
Source: HCFA OMC

Chart MC-3

Relative Growth in HMO Enrollment

Medicare (Risk HMOs) and Non-Medicare Populations



% Medicare Change	6%	7%	11%	10%	13%	16%	25%
% Non-Medicare Chg	12%	6%	5%	6%	7%	9%	11%

✳ % Medicare Change + % Non-Medicare Chg

Source: HCFA OMC; Group Health Association of America

Chart MC-4

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HMO penetration varies by state and type of enrollment.

- Total Medicare managed care enrollment lags behind the level of enrollment in the commercial sector. In the nation as a whole, 17.4% of the population is enrolled in an HMO (using a more expansive definition of managed care would raise the level to about 50%, by including health plan options that have managed care features, such as preferred provider organizations that provide services through a selected network of providers). Fewer than 7% of Medicare beneficiaries are enrolled in risk plans.

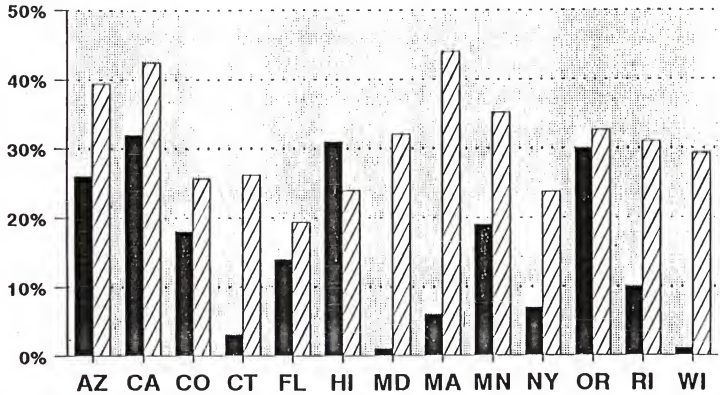
- HMO penetration (the extent to which individuals enroll in managed care plans) varies across States, for both Medicare and the commercial sector (Chart MC-5).

  - In 1993, two States had Medicare (cost or risk) HMO enrollment penetration levels that were higher than the level of penetration for the non-Medicare insured population of the State.

State	% of Total Pop. in HMOs	% of Medicare Pop. in HMOs
HAWAII	24%	31%
NEVADA	12%	20%

Medicare and Non-Medicare HMO Penetration, 1992

In Selected States with Significant HMO Enrollment



	AZ	CA	CO	CT	FL	HI	MD	MA	MN	NY	OR	RI	WI
Medicare Risk/Cost	26%	32%	18%	3%	14%	31%	1%	6%	19%	7%	30%	10%	1%
Non-Medicare	39%	42%	26%	26%	19%	24%	32%	44%	35%	24%	33%	31%	29%

■ Medicare Risk/Cost ▨ Non-Medicare

Non-Medicare Penetration As % of Insured Population in HMOs (Medicare and Uninsured Excluded)
Source: HCFA OMC, Group Health Association of America

Chart MC-5

The level of Medicare HMO penetration does not necessarily vary by the level of Medicare HMO payments.

- Among the top 15 counties in terms of 1993 AAPCC payment, only Southern California and South Florida counties have high Medicare HMO enrollment (Chart MC-6). (Los Angeles and Orange county rank 10th and 13th in AAPCC levels. Dade county ranked 7th.)

- Detroit, New York (with counties ranking 1, 2, and 3 in AAPCC levels) and Philadelphia (ranking 6th), though high AAPCC payment areas, have negligible Medicare HMO risk enrollment.

- Some counties with very low Medicare AAPCC payments have a very high percentage of Medicare risk HMO enrollment (Chart MC-7).

    - Such counties are in areas that have historically had high levels of non-Medicare HMO membership.

Medicare Risk HMO Enrollment in High Payment Areas

Ranked by 1994 AAPCC Level

COUNTY	1993 ELIGIBLES	1993 RISK ENROLLMENT	% of Medicare Enrollees in Risk HMOs	% of Total Population in HMOs (in MSA)	Ratio of AAPCC to USPCC	Rank of AAPCC Level	Number of Risk Contractors
BRONX	150,491	5,256	3%	14%	182%	1	4
RICHMOND, NY	52,004	4,685	9%	14%	175%	2	4
NEW YORK CITY	209,995	4,036	2%	14%	174%	3	4
ST. BERNARD, LA	10,068	2	0%	19%	171%	4	0
KINGS, NY	301,512	9,580	3%	14%	170%	5	4
PHILADELPHIA	268,019	10,491	4%	28%	169%	6	3
DADE, FL	287,394	75,588	26%	17%	160%	7	7
QUEENS	289,908	12,507	4%	14%	156%	8	4
WAYNE, MI	309,602	1,941	1%	25%	150%	9	1
LOS ANGELES	947,517	299,673	32%	36%	148%	10	9
OAKLAND, MI	140,348	474	0%	25%	145%	11	1
BROWARD, FL	253,675	77,725	31%	17%	144%	12	7
MACOMB, MI	108,086	483	0%	25%	139%	13	1
ORANGE, CA	250,631	77,429	31%	36%	139%	14	9
PLAQUEMINES, LA	2,660	0	0%	19%	126%	15	0
PALM BEACH	216,051	46,372	21%	17%	126%	16	7

Total Enrollment	626,242
% of All Risk Enrollment	36%

Chart MC-6

Source: HCFA OMC, Group Health Association of America

High Penetration Counties with AAPCC of 100% or Less of USPCC

For Counties with Medicare Population of 20,000 or More Ranked by AAPCC Level

State	County	Medicare Population 1993	Medicare 1993 Cost/Risk Enrollees	1993 Medicare %	1991 Non-Medicare %	Ratio of 1994 AAPCC to 1994 USPCC
MN	ST. LOUIS (Duluth/Superior)	37,480	8,011	21%	30%*	74%
OR	MARION (Salem)	41,045	11,227	27%	32%*	76%
WA	CLARK (Portland)	31,652	7,621	24%	34%	84%
IL	ROCK ISLAND (Davenport-Moline-RI)	25,727	2,554	10%	16%*	85%
IN	VANDERBURGH (Evansville)	30,607	3,660	12%	7%*	85%
IA	BLACK HAWK (Waterloo-Cedar Rapids)	20,351	3,087	15%	4%*	88%
CO	PUEBLO	22,890	5,433	24%	23%*	91%
OR	CLACKAMAS (Portland)	35,308	18,174	51%	34%	91%
CO	EL PASO (Colorado Springs)	41,732	4,686	11%	23%*	92%
HI	HONOLULU	105,169	29,828	28%	24%	94%
CO	BOULDER	22,676	3,319	15%	23%*	97%
MN	HENNEPIN (Minneapolis)	139,429	57,065	41%	46%	98%
OR	WASHINGTON (Portland)	34,158	15,070	44%	34%	98%
MN	RAMSEY (St. Paul)	72,675	25,968	36%	46%	100%
OR	MULTNOMAH (Portland)	94,114	43,512	46%	34%	100%

** Non-Medicare HMO Penetration in State Used Where MSA Penetration Unknown*

Source: HCFA OMC, Group Health Association of America

Chart MC–7

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A large majority of risk HMO enrollees are in plans with premiums well below the levels of premiums for Medicare supplemental (Medigap) insurance (Chart MC-8).

- Medicare beneficiaries enrolled in HMOs with the highest AAPCC payments are offered zero-premium plans and receive free additional benefits, including outpatient prescription drug coverage (Chart MC-9).

  - As of 1993, nearly 50% of all Medicare risk HMO enrollees were enrolled in zero-premium plans offering outpatient prescription drugs (Chart MC-10).

- While Federally-qualified HMOs are not required to include outpatient prescription drugs in their basic benefit package, a greater proportion of non-Medicare HMO enrollees have an outpatient prescription drug benefit than Medicare HMO enrollees. According to the Group Health Association of America, 97% of HMO enrollees have prescription drug coverage in the commercial sector.

Comparison of Yearly Medigap Premiums and Risk HMO Premiums (1993/1994 Data)

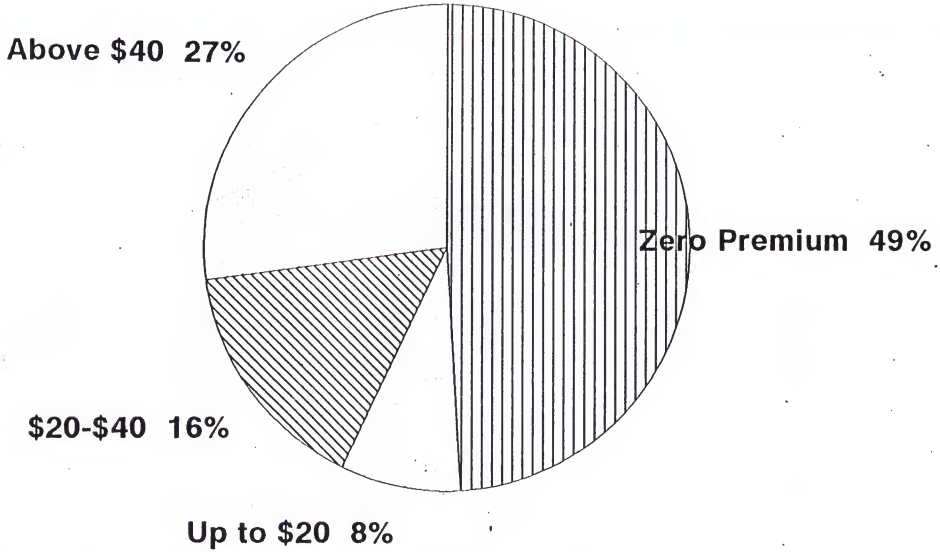
	Part B Premium (1994)	HMO Premiums		Medigap Premiums	
		Lowest HMO Premium	Highest HMO Premium	HCFA Data on Lowest Medigap (Plan F: Age 65 Issuance)	Consumers' Union Lowest Medigap (Plan C: Community Rated)
Los Angeles	$493.20	$0	$264	$889	$963
Miami	$493.20	$0	$60	$820	$999
New York City	$493.20	$0	$684	$1,706	$936
Cleveland	$493.20	$830	$857	$899	$783
Minneapolis	$493.20	$635	$780		$311

NOTE: Medicare Enrollees of HMOs Are Required to Have Part B and Must Pay Their Own Part B Premium; The Zero-Premium HMOs Listed Include Coverage of Prescription Drugs; The Medigap Plans Listed Do Not; Medigap Plan F Includes Coverage of Coinsurance and Deductibles as Well as Balance Billing; Medigap Plan C Does Not Have Balance Billing Protection

Source: HCFA OLIGA; Consumer Reports, August 1994

Chart MC-8

Distribution of Medicare Risk HMO Monthly Premium Levels (April, 1993)



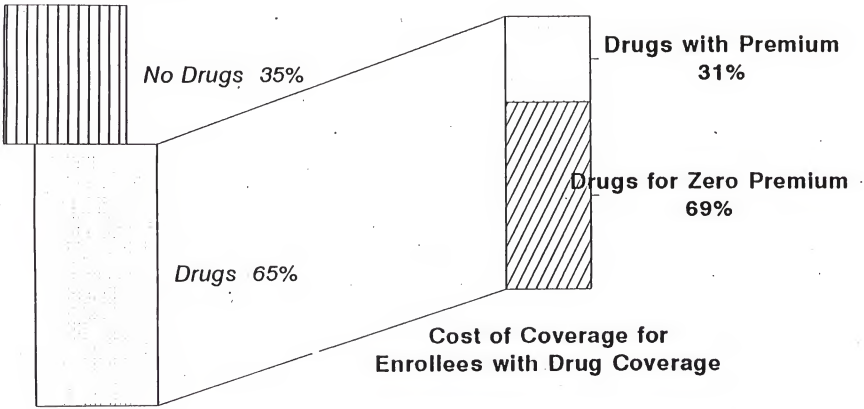
Expressed As Percent of Total Medicare Risk Enrollees In Each Category
Source: HCFA OLIGA Survey of Medicare HMOs

Chart MC-9

Drug Coverage Among Medicare Beneficiaries in Risk HMOs

By Proportion of Beneficiaries with/without Coverage

Extent of Coverage



Source: HCFA Office of Legislative and Intergovernmental Affairs, 4/93 Survey of Plans

Chart MC-10

Nearly 10% of payments to risk HMOs are used to provide additional benefits to Medicare enrollees.

- In 1991, beneficiaries enrolled in risk HMOs received up to $115 per month in additional benefits or reduced premiums.

- Weighted by plan enrollment, the average amount of "savings" passed on to Medicare enrollees of risk HMOs was $39.36 per month.

Table MC-11 uses data from the ACR filings of all risk HMOs to provide information about additional benefits provided to Medicare enrollees in 1991. (Appendix II provides an explanation of the ACR process.)

Level of AAPCC Payments Used for Additional Benefits/Cost Reductions, 1991
Based on Premium Proposals Submitted to HCFA

YEAR 1991	Projected Average Payment Rate	Proposed Premium (Adjusted Community Rate (ACR))	Savings Returned As Additional Benefits/ Reduced Premiums (Statutory)	Additional Reductions Of Premiums Or Cost Waiver (Voluntary by Plan)	Plans with Savings and Waivers	Total $$ Returned to Enrollees	Portion of ACR Allocated to Medicare Administration (Includes Profit)
Average	$287.28	$323.05	$10.34	$13.23	$12.40	$10.34	$47.75 (17%)
Maximum	$429.85	$492.31	$97.51	$79.49	$115.23	$115.23	$185.91 (38%)
Lowest	$187.36	$205.97	$0.00	$0.00	$18.22	$0.00	$1.65 (1%)
Avg. Wtd.by Projected Enrollment	$312.35	$344.11	$13.97	$25.39	$19.57	$39.36	$46.89 (15%)

- **Total Projected Payments, 1991: ..... $5.8 billion**
- **Total Returned to Beneficiary: ..... $553 million**

- **PERCENT OF PAYMENTS RETURNED TO BENEFICIARY: 9.4%**
- **% OF BENEFICIARIES WITH RETURNED $$ (Savings or Waivers): 95.2%**

Source: HCFA OMC

Chart MC-11

APPENDIX I

OVERVIEW OF THE MEDICARE PROGRAM

What is Medicare?

Medicare, authorized under title XVIII of the Social Security Act, is a nationwide health insurance program for the aged and certain disabled persons. It was enacted in 1965, and consists of two parts:

Hospital Insurance (Part A)

- Individuals eligible for Social Security *are automatically entitled* when they reach age 65.
- Individuals *under age 65* and eligible for Social Security disability must have been disabled for at least two years.
- Persons with end-stage renal disease.
- Individuals over age 65 who are *not automatically entitled* may enroll in Part A if they pay a monthly premium.
- Financed through payroll taxes on workers and their employers (FICA tax).
- Covers inpatient hospital, skilled nursing facility, home health, and hospice care.

Supplementary Medical Insurance (Part B)

- Voluntary.
- Enrollment open to individuals 65 or older, or those already entitled to Part A benefits.
- Financed through general revenues (about 75% of program costs) and enrollee premiums (about 25% of program costs).
- Covers physicians' and other outpatient medical services (and home health care for those without Part A).

Enrollment Trends and Projections*

An estimated 97% of the total elderly population has some type of Medicare coverage. Approximately 94% of the total Medicare population is covered by both Part A and Part B.

Who Is Enrolled In Medicare Part A?

- In fiscal year 1994, approximately 32.2 million aged and 4.1 million disabled individuals were enrolled in the Medicare Hospital Insurance (Part A) program. Of those, it is estimated that approximately 6.9 million aged and 0.9 million disabled enrollees will actually receive reimbursed services.

- Between 1990 and 1995, the number of those enrolled in Medicare Part A is estimated to grow by approximately 9.5%. By the year 2000, the total number of enrollees is projected to have increased by 17.8% over the course of the decade, reaching a total of 39.8 million beneficiaries in 2000.

Who Is Enrolled In Medicare Part B?

- In fiscal year 1994, approximately 31.4 million aged and 3.6 million disabled individuals were enrolled in the Medicare Supplementary Medical Insurance (Part B) program. Of those, 26.1 million aged and 2.9 million disabled enrollees will receive Part B reimbursed services.

- Between 1990 and 1995, the number of those enrolled in Medicare Part B is estimated to grow by approximately 9.2%. By the year 2000, the total number of enrollees is projected to have increased by 16.9% over the course of the decade, reaching a total of 38.1 million beneficiaries in 2000.

End Stage Renal Disease

- The Medicare program covers nearly all individuals who suffer from end stage renal disease (ESRD). Benefits for qualified ESRD beneficiaries include all Part A and Part B medical items and services.

- New ESRD enrollments grew at an average annual rate of about 10% from 1982 to 1992. In 1980, there were approximately 28 thousand ESRD enrollees, and by 1992 that number had risen to nearly 72 thousand. The growth in program participation is attributable to growth in the numbers of elderly people receiving services and growth in the number of more seriously ill people entering treatment.

*Source: HCFA/OACT

Medicare Cost Sharing
1995

- Inpatient Hospital Deductible = $716 per benefit period
- Part B Deductible = $100 per year
- Part B Premium = $46.10 per month
- In addition, beneficiaries pay copayments for SNF, extended hospital stays, and co-insurance for physician, durable medical equipment, supplier and hospital outpatient services.

APPENDIX II

OVERVIEW OF THE MEDICARE MANAGED CARE PROGRAM

The Basics of Medicare HMOs...

Health Maintenance Organizations (HMOs) and similar types of organized health care delivery systems have the option of contracting with HCFA to provide services to Medicare enrollees.

Medicare payment to HMOs is either on a risk or a cost basis. Risk HMOs are paid a pre-determined per-member payment to provide all necessary covered services to their Medicare enrollees. HCFA determines a risk HMO's monthly capitation payments based on yearly projections of Medicare program costs for non-HMO beneficiaries in a given county. An at-risk HMO receives 95% of the **"adjusted average per capita cost" (AAPCC)** for each of its members. The AAPCC varies by county, and also varies by demographic factors of individual enrollees (age, sex, Medicaid status, and other factors). At this time, HCFA does not have sufficient data to adjust the AAPCC based on an individual's health status.

As with non-Medicare enrollees of HMOs, in general, Medicare members of a risk HMO are "locked in" to the HMO for all Medicare-covered services, except in the event of an emergency. That is, care is covered as long as the member uses providers authorized by the HMO to provide care. However, under current law, Medicare HMO enrollees are free to disenroll from an HMO on a month-to-month basis (as contrasted with the typical year lock-in required by employer-sponsored HMOs among the working population).

HMOs and similar organizations can also receive Medicare payment on a cost reimbursement basis. Medicare will pay the HMO the actual cost of providing care to Medicare enrollees. The HMO is not "at risk" in that event, and Medicare enrollees of such organizations are not "locked in" to the

HMO for services. Medicare will continue to pay for "out-of-plan" services billed to Medicare's carriers and intermediaries.

Another option for HMOs in some States is to obtain fee-for-service reimbursement on behalf of enrollees of a Medigap plan that limits its Medigap coverage to in-plan services (Medicare Select).

The Adjusted Community Rate (ACR) Premium Approval Requirements

Medicare law provides that if a risk HMO's projected AAPCC payments in a given year are expected to exceed the costs of providing care to the organization's Medicare enrollees (including any profit of a for-profit entity), the HMO must either accept a reduced payment or return the savings to Medicare enrollees in the form of reduced out-of-pocket expenditures (premiums and copayments) and/or in the form of additional benefits not otherwise covered by Medicare.

In some areas of the country, HMOs also "waive," or decline to collect, cost-sharing amounts from Medicare enrollees. For Medicare-covered services, HMOs may collect from their enrollees the equivalent of Medicare's fee-for-service coinsurance and deductibles (e.g., the hospital deductible or coinsurance on physician services). The AAPCC payment from HCFA includes only actual program expenditures, not beneficiary liability amounts.

Because of the return of savings provisions, and because of the practice of waiving otherwise collectible amounts, beneficiaries in many HMOs have little or no out-of-pocket expenses and have relatively rich benefit packages--including coverage of prescription drugs. This is particularly true in high AAPCC areas, such as Miami and Los Angeles, where HMOs can operate at costs well below regional fee-for-service levels of cost.

Prior to the beginning of each contract year, HCFA reviews rate proposals and benefit packages proposed by each risk HMO. This **adjusted community rate or ACR** process determines whether an HMO will be in a position of having to return savings to its Medicare enrollees. As part of the ACR process, HMOs also advise HCFA as to whether premiums or other cost sharing will be waived.

Medicare HMOs and favorable selection

- Medicare payments to risk HMO enrollees are adjusted by demographic factors such as age, but no adjustment is made for individual health status.

- Research has found that Medicare HMOs enroll healthier-than-average Medicare beneficiaries, primarily because such individuals "self-select" into HMOs.

- A study of 1989 enrollees in Medicare risk HMOs by Mathematica Policy Research showed that Medicare was incurring costs of 5.7% more for enrollees in HMOs than the program would have incurred had the individuals remained in fee-for-service Medicare. The higher payment may be attributable, in part, to the absence of a health status adjuster.

- Mathematica found that Medicare risk HMOs delivered care of comparable quality to fee-for-service Medicare.

  - HMOs provide this level of care using fewer inpatient and ambulatory resources as compared to Medicare fee-for-service.

- Medicare HMOs appear to spend about 10% less for care than would have been spent in fee-for-service.

- Medicare HMO enrollees are somewhat less satisfied with their care but more satisfied than fee-for-service beneficiaries with costs. HMO enrollees also have broader coverage (including, for example, coverage of preventive care).